Commonwealth of Kentucky
Department for Medicaid Services
Documentation Guidelines
Related To RUG-III, Version 5.12, 34-Group

***Revised 8/2008 to include CMS' MDS Tip Sheet: Item H3A, May 2008 will be Effective 10/2008 Audits**
***CMS Revisions at R2b, July 2008 will be Effective 1/2009 Audits**

Addendum Items

- Hospital documentation present in the clinical record shall validate any response(s) on the MDS 2.0 that reflect the resident's hospital stay prior to admission, if the dates are within the observation period that ends on the A3a date.

- The A3a date is the last day of the MDS observation period. This date refers to a specific end-point in the MDS assessment process. The A3a date sets the designated end-point of the observation period. All MDS items refer back in time from this end-point.

- CMS clarification: "For example, for a MDS item with a 7-day period of observation (look back period), assessment information is collected for a 7-day period ending on and including the Assessment Reference Date (ARD), which is the 7th day of this observation period. For an item with a 14-day observation period (look back period), the information is collected for a 14-day period ending on and including the ARD (Item A3a)".

- For validation purposes, number codes that are "written over" will not be considered. Only legal corrections will be accepted as a valid number code.

- For validation purposes, electronic signatures/initials are acceptable. The PRO shall be required to verify training on a staff person that has changed their name (due to marriage, divorce, etc.) by checking their Social Security number per Task Force.

- The Resident Assessment Protocols (RAPs) documentation occurs after the A3a date and, therefore, will NOT be utilized to validate the Minimum Data Set (MDS). The focus is on documentation during the observation period that ends on the A3a date.

- CMS – "It is important to observe, interview and physically assess the resident, and to interview staff. The MDS was designed to consider information obtained from family members, although it is not necessary that every discussion with them be face-to-face. Assessors should capture information that is based on what actually happened during the observation period, not what usually happens. Problems may be missed when the resident's actual status over the entire observation period is not considered."

- CMS – "Assessors must capture the resident's ACTUAL status and performance, and what care was ACTUALLY provided during the entire observation period. This includes gathering information from a variety of staff and/or gathering information across shifts, when indicated by the MDS Item coding instructions. Not every nuance will be documented in the clinical record. Therefore, it's important to obtain information from the residents and direct care givers. To code the MDS accurately, multiple sources of information must be used, such as: interview, observation and assessment of the resident, communication with direct care staff and other disciplines working with the resident, contact with family, and clinical records review. It is not necessary that one assessor must do all of this him/herself. It's up to the facility to establish systems, policies and procedures to facilitate the RAI processes, and accurate MDS coding."

- CMS – "Facilities exhibiting a pattern of multiple corrections may be subject to stringent MDS review during survey. If the surveyor identifies an error pattern impacting Medicare or Medicaid reimbursement, we would expect the survey agency to alert the FI or state Medicaid agency of the problem."

- DMS – Hospice residents shall not be included on RUG validation reviews. If a Hospice resident is included on the resident roster during the look back period, the field review nurse will be required to choose an alternate resident to review and contact Myers & Stauffer.

- DMS – "Facilities may print computer generated or manual resident assessment records. There is no requirement to maintain two copies of the form in the resident's record. (Either a hand written or a computer-generated form is equally acceptable.) It is required that the record be completed, signed and dated within the regulatory time frames, and maintained for 15 months in the resident's active record. (For those providers who maintain manual records, it is acceptable for 15 months of MDS information to be kept at the nurse's station in a binder.) If changes are made after completion, those changes must be made to the electronic record, and indicated on the form using standard medical records procedure. It may also be appropriate to update the resident's care plan, based on the revised assessment. Resident assessment forms must accurately reflect the resident's status, and agree with the record submitted to the CMS standard system at the State."

- DMS – "Some nursing facilities are now changing to all electronic medical records. DMS shall require those nursing facilities to provide the PRO nurse(s) access to a computer to complete any on-site review required for Medicaid reimbursement.

Activities of Daily Living (ADL)		
MDS 2.0 LOCATION	**FIELD DESCRIPTION**	**DOCUMENTATION GUIDELINES**
Section G	**Physical Functioning and Structural Problems**	Most nursing facility residents are at risk of physical decline. Most long-term and many short-term residents also have multiple chronic illnesses and are subject to a variety of other factors that can severely impact self-sufficiency. For example, cognitive deficits can limit ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency. Due to these many, possibly adverse influences, a resident's potential for maximum functionality is often greatly underestimated by family, staff, and the resident himself or herself. Thus, all residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs. Individualized plans of care can be successfully developed only when the resident's self-performance has been accurately assessed and the amount and type of support being provided to the resident by others has been evaluated. See Section 1.13 on the use of an interdisciplinary team to provide the most accurate assessment of each resident.
G1(A)	**Activities of Daily Living (ADL) Self-Performance**	**Intent:** To record the resident's self-care performance in activities of daily living (i.e., what the resident actually did for himself or herself and/or how much verbal or physical help was required by staff members) during the last 7 days. **Definition: ADL Self-Performance –** Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.
	<u>Addendum Item</u>	It is acceptable that the documentation for the four (4) late-loss activities of daily living (ADLs): Bed Mobility, Transfer, Eating, and Toilet Use can be <u>EITHER per shift OR on a daily basis</u>, at the Provider's option during the observation period that ends on the A3a date.
G1a	**Bed Mobility**	**Definition –** How the resident moves to and from a lying position, turns side to side, and positions body while in bed, in a recliner, or other type of furniture the resident sleeps in, rather than a bed.
G1b	**Transfer**	**Definition –** How the resident moves between surfaces – i.e., to/from bed, chair, wheelchair, standing position. Exclude from this definition movement to/from bath or toilet, which is covered under Toilet Use and Bathing.

G1h	**Eating**	**Definition –** How the resident eats and drinks, regardless of skill. <u>Do not include eating/drinking during medication pass.</u> Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition). Even a resident who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and is not coded as an "8". The resident must be evaluated under the Eating ADL category for his/her level of assistance in the process. A resident who is highly involved in giving himself/herself a tube feeding is not totally dependent and should not be coded as "4".
	<u>Addendum Item</u>	A resident is NOT coded a "2" in self-performance in eating due to food being prepared by the dietary staff and nursing carrying trays to the room or table in the dining room. The self-performance coding for eating should be specific to what the resident can do for himself.
G1i	**Toilet Use**	**Definition –** How the resident uses the toilet room, commode, bedpan, or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes. Do not limit assessment to bathroom use only. Elimination occurs in many settings and includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter, and clothing adjustment.
	<u>Addendum Item</u>	"A resident who is totally dependent for staff to manage their Foley catheter but does their own care for managing bowel movements should be coded as "0". The issue of the catheter, which is continence status, will be coded at Section H." (per CMS). **Process:** In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.) A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nurse assistant he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well. In order to accomplish this, it is necessary to gather information from multiple sources – i.e., interviews/discussion with the resident and direct care staff on all three shifts, including weekends and review of documentation used to communicate with staff across shifts. Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Bed Mobility with a nurse assistant, be sure to inquire specifically how the resident moves to and from a lying position, how the resident turns from side to side, and how the

G1(A)	**ADL Self-Performance**	resident positions himself or herself while in bed. A resident can be independent in one aspect of Bed Mobility yet require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully. The wording used in each ADL performance coding option is intended to reflect real-world situations where slight variations in performance are common. Where small variations occur, the coding ensures that the resident is not assigned to an excessively independent or dependent category. For example, by definition, codes 0, 1, 2, and 3 (Independent, Supervision, Limited Assistance and Extensive Assistance) permit one or two exceptions for the provision of heavier care within the assessment period. For example, in scoring a resident as independent in ADL Self-Performance, there can be one or two exceptions. As soon as there are three exceptions, another code must be considered. While it is not necessary to know the actual number of times the activity occurred, it is necessary to know whether or not the activity occurred three or more times within the last 7 days. Because this section involves a two-part evaluation (Item G1A. ADL Self-Performance and Item G1B, ADL Support), each using its own scale, it is recommended that you complete the Self-Performance evaluation for all ADL Self-Performance activities before beginning the ADL Support evaluation. To evaluate a resident's ADL Self-Performance, begin by reviewing the documentation in the clinical record. Talk with clinical staff from each shift to ascertain what the resident does for himself or herself in each ADL activity as well as the type and level of staff assistance being provided. As previously noted, be alert to differences in resident performance from shift to shift, and apply the ADL codes that capture these differences. For example, a resident may be independent in Toilet Use during daylight hours but receive non-weight bearing physical assistance every evening. In this case, the resident would be coded as "2" (Limited Assistance) in Toilet Use. The following chart provides general guidelines for recording accurate ADL Self-Performance and ADL Support assessments: Guidelines for Assessing ADL Self-Performance and ADL Support • The scales in Items G1A and G1B are used to record the resident's actual level of involvement in self-care and the type and amount of support actually received during the last 7 days. • Do not record your assessment of the resident's capacity for involvement in self-care – i.e., what you believe the resident might be able to do for himself or herself based on demonstrated skills or physical attributes. For nursing facilities, an assessment of potential capability is covered in

G1(A)	**ADL Self-Performance**	Item G8 (ADL Functional Rehabilitation Potential). • Do NOT record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The type and level of assistance actually provided might be quite different from what is indicated in the plan. Record what is actually happening. • Engage direct care staff, from all shifts, which have cared for the resident over the last 7 days in discussions regarding the resident's ADL functional performance. Remind staff that the focus is on the last 7 days only. To clarify your own understanding and observations about each ADL activity (bed mobility, locomotion, transfer, etc.) ask probing questions, beginning with the general and proceeding to the more specific.
	Clarification:	• Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one self-performance category to another, demands an increase or decrease in the number of times that help is provided. Thus to move from Independent to Supervision to Limited Assistance, non weight-bearing supervision or physical assistance must increase from one or two times up to three or more times during the last 7 days. There will be times when no one type of level of assistance is provided to the resident 3 or more times during a 7-day period. However, the sum total of support of various types will be provided 3 or more times. In this case, code for the least dependent self-performance category where resident received that level or more dependent support 3 or more times during the 7-day period. (See examples on page 3-82.) Additional clarification and coding examples are presented on p. 3-82 through 3-90. Further clarification of ADL coding policy is presented starting on p. 3-92.
	<u>Addendum Items</u>	• Task Force, "The physical therapy documentation must meet the DMS Minimum Criteria Required for ADL Documentation dated 4/1/2001 (i.e., A "key" descriptor must be available and correspond with the MDS/ADL definitions in the MDS User's Manual.)" • Nurse Aide Care Plans are NOT acceptable for supporting the 4 late-loss ADLs UNLESS they meet the "DMS Minimum Criteria Required for ADL Documentation".
(7-day look back)	**p. 3-76 to 3-90**	**Documentation for all self-performance elements (what the resident actually did) shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**

G1(B)	**ADL Support Provided**	**Intent:** To record the type and highest level of support the resident received in each ADL activity over the last 7 days. **Definition:** **ADL Support Provided –** Measures the highest level of support provided by staff over the last 7 days, even if that level of support only occurred once. This is a different scale, and is entirely separate from the ADL self-Performance assessment. **Set-Up Help –** The type of help characterized by providing the resident with articles, devices or preparation necessary for greater resident self-performance in an activity. This can include giving or holding out an item that the resident takes from the caregiver. Examples of set-up help: **a. For bed mobility –** handing the resident the bar on a trapeze, **staff** applies ½ rails and then provides no further help. **b. For transfer –** giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer. **h. For eating –** cutting meat and opening containers at meals; giving one food category at a time. **i. For toilet use –** handing the resident a bedpan or placing articles necessary for changing ostomy appliance within reach. **Process:** For each ADL category, code the maximum amount of support the resident received over the last 7 days, irrespective of frequency, and enter in the "SUPPORT" column. Be sure your evaluation considers all nursing shifts, 24 hours per day, including weekends. Code independently of the resident's Self-Performance evaluation. For example, a resident could have been Independent in ADL Self-Performance in Transfer but received one-person physical assist one or two times during the 7-day period. Therefore, the ADL Self-Performance Coding for Transfer would be "0" (Independent), and the ADL Support coding "2" (One-person physical assist). (Refer to examples beginning on p.3-94 through 3-100 for both Self-Performance and Support clarification.)
	Clarifications:	• General supervision of a dining room is not the same as individual supervision of a resident. If the resident ate independently, then MDS Item G1h is coded as "0" (Independent). If the individual resident needed oversight, encouragement or cueing during the last 7 days, the item is coded as a "1" (Supervision). For a resident who has received oversight, encouragement, or cueing and also received more help, such as physical assistance provided one or two times during the 7-day assessment period, the resident would still be coded as a "1" (Supervision). Residents who are in

G1(B)	**ADL Support Provided Clarifications:**	"feeding" or eating" groups and who are individually supervised during the meal would be coded as "1" (Supervision) for Self-Performance in Eating. • The key to the differentiation between guided maneuvering and weight-bearing assistance is determining *who* is supporting the weight of the resident's hand. If the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his/her mouth, this is guided maneuvering. • If therapists are involved with the resident, their input should be included either by way of an interview or by the assessor reviewing the therapy documentation. The resident may perform differently in therapy than on the unit. Also focus on occurrences of exceptions in the resident's performance. When discussing a resident's ADL performance with a therapist, make sure the therapist's information can be expressed in MDS terminology.
	"8" Clarifications:	CLARIFICATIONS USING THE CODE "8" (ACTIVITY DID NOT OCCUR): • If the resident is bed bound and does not walk and there was no locomotion via bed, wheelchair or other means, then you would code an "8" for transfer and locomotion. However, if the bed is moved in order to provide locomotion on or off the unit, then you would code according to the definitions provided in Section G1A and B. • A resident who has not been out of bed in the past 7 days could be coded "8" for (A) and (B) in MDS Sections G1b-f, unless the bed was moved (locomotion on/off unit). Other ADLs are considered individually. • The eating item for G1h is a little more complex. If in the past 7 days, the resident truly did not receive any nourishment, the item would be coded "8". It should go without saying that this is a serious issue. Be careful not to confuse total dependence with eating (code "4") with the activity itself (in this case, receiving nourishment and fluids). Keep in mind that a resident who is fed via tube, and manages the tube feeding independently is coded as independent (code "0"). G1h includes receiving IV fluids. For a resident who is receiving fluids for hydration, and is totally dependent, this is coded as "4" rather than "8".

G1(B) **7-day look back)**	**ADL Support Provided** **<u>Addendum Item</u>** **p. 3-91 to 3-100**	• Toilet use focuses on whether or not elimination occurs, rather than the process. The elimination may be in the toilet room, commode, in the bedroom on a bedpan or urinal. It includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter and clothing adjustment. The "8" code is rarely used in this section, as it would indicate that elimination did not occur. • Nurse Aide Care Plans are NOT acceptable for supporting the 4 late-loss ADLs UNLESS they meet the "DMS Minimum Criteria Required for ADL Documentation". **Documentation for all support elements (what type and highest level of support the resident actually received) shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
Section K **K5** **K5a**	**Oral/Nutritional Status** **Nutritional Approaches** **Parenteral/IV**	Residents in nursing facilities challenge the staff with many conditions that could affect their ability to consume food and fluids to maintain adequate nutrition and hydration. Early problem recognition can help to ensure appropriate and timely nutritional intervention. Prevention is the goal, and early detection and modification of interventions is the key. Section K, Oral and Nutritional Status, should assist the nursing facility staff in recognizing nutritional deficits that will need to be addressed in a resident's care plan. Nurse assessors will need to collaborate with the dietitian and dietary staff to ensure that some items in this section have been assessed and calculated accurately. Keep in mind that Section 1.13 states that the RAI must be conducted or coordinated with the appropriate participation of health professionals…facilities have flexibility in determining who should participate in the assessment process, as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment. **Definition:** Include only fluids administered for nutrition or hydration, such as: • IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently. • IV fluids running at KVO (Keep Vein Open) • IV fluids administered via heparin locks • IV fluids contained in IV piggybacks • IV fluids used to reconstitute medications for IV administration

K5 **(7-day look back)**	**Parenteral/IV** **p. 3-153**	DO NOT INCLUDE: • IV medications • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay • IV fluids administered solely as flushes • Parenteral/IV fluids administered during chemotherapy or dialysis For coding IV medications, see page 3-182. **Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
K5b **(7-day look back)**	**Feeding Tube** **Clarification:** **p. 3-153 & 3-154**	**Definition:** Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tube. ♦ If the resident receives fluids by hypodermoclysis and subcutaneous ports in hydration therapy, code these nutritional approaches in the item. The term parenteral therapy means "introduction of a substance (especially nutritive material) into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous)." If the resident receives fluids via these modalities, also code Items K6a and K6b, which refer to the caloric and fluid intake the resident received in the last 7 days. Additives such as electrolytes and insulin which are added to the resident's TPN or IV fluids should be counted as medications and documented in Section O1, Number of Medications AND P1ac, IV Medications. **Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
K6 **K6a**	**Parenteral or Enteral Intake** **Proportion of Total Calories**	**Intent:** To record the proportion of calories received and the average fluid intake through parenteral or tube feeding in the last 7 days. **Definition:** The proportion of all calories ingested during the last 7 days that the resident actually received (not ordered) by parenteral or tube feedings. Determined by calorie count. **Process:** Review intake record. If the resident took no food or fluids by mouth, or took just sips of fluid, stop here and code "4" (76%-100%).

K6a **(7-day look back)**	**Proportion of Total Calories** **Addendum Items** **p. 3-155 & 3-156**	A resident receiving intake by mouth and tube feeding MUST have a calorie count for BOTH the intake by mouth AND the tube feeding in order to determine the proportion ratio of total calorie intake during the observation period that ends on the A3a date. (i.e., example on p. 3.155). When a resident is receiving IV fluids of D 5 1/2 solution for dehydration, the glucose provided in the IV would NOT be coded under Medications. Since the glucose is most likely being given for caloric value, the facility should code K6a for total calories received during the observation period that ends on the A3a date. However, if the glucose were being given to maintain sugar levels for a diabetic, it would be coded under IV medications. Example of Calculation for Proportion of Total Calories from IV or Tube Feeding Mr. H has had a feeding tube since his surgery. He is currently more alert and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past week, he has been receiving tube feedings for nutritional supplementation. As his oral intake improves, the amount received by tube will decrease. The dietitian has totaled his calories per day as follows: Step #1: Oral + Tube Sun. 500 + 2000 Mon. 250 + 2250 Tues. 250 + 2250 Wed. 350 + 2250 Thurs. 500 + 2000 Fri. 800 + 800 Sat. 800 + 1800 TOTAL 3450 14350 Step #2: Total calories = 3450 = 14350 = 17800 Step #3: Calculate percentage of total calories by tube feeding. 14350/17800 = .806 X 100 = 80.6% Step #4: Code “4” for 76% to 100% **Documentation of the proportion of calories ingested that the resident actually received (not ordered) by parenteral or tube feedings shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**

K6b	**Average Fluid Intake**	**Definition:** Average fluid intake per day by IV or tube feeding in last 7 days refers to the actual amount of fluid the resident received by these modes (not the amount ordered). **Process:** Review the Intake and Output record from the last 7 days. Add up the total amount of fluid received each day by IV and/or tube feedings only. Also include the water used to flush as well as the "free water" in the tube feeding (based upon the percent of water in the specific enteral formula). The amount of heparinized saline solution used to flush a heparin lock is NOT included in the average fluid intake calculation, while the amount of fluid in an IV piggyback solution is included in the calculation. Divide the week's total fluid intake by 7. This will give you the average of fluid intake per day. Example of Calculation for Average Daily Fluid Intake Mrs. A has swallowing difficulties secondary to Huntington's disease. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration. She received the following daily totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days. Step #1: Sun. 1250 cc Mon. 775 cc Tues. 925 cc Wed. 1200 cc Thurs. 1200 cc Fri. 1200 cc Sat. 1000 cc TOTAL 7550 cc Step #2: 7550 divided by 7 = 1078.6 cc Step #3: Code "3" for 1001 to 1500 cc/day
	Clarifications:	♦ The basic TPN solution itself (that is, the protein/carbohydrate mixture or a fat emulsion is NOT counted as a medication. The use of TPN is coded in Item K6a. When medications such as electrolytes, vitamins, or insulin have been added to the TPN solution, they are considered medications and should be coded in O1. ♦ The amount of heparinized saline solution used to flush a heparin lock is NOT included in the average fluid intake calculation. The amount of fluid in an IV piggyback solution is included in the calculation. **Documentation of the actual amount of fluid the resident received (not the amount ordered) by IV and/or tube feeding shall be present in the clinical record during the 7-day observation period that ends on the A3a date. Divide the week's total fluid intake by 7 to validate the average of fluid intake per day.**
(7-day look back)	**p. 3-156 to 3-158**	

STEP 1: To calculate the score of G1a, G1b and G1i, use the following chart below:

Column A =	Column B =	ADL score =
- , 0 or 1	(and) any #	= 1
2	(and) any #	= 3
3, 4, or 8	(and) - , 0, 1, or 2	= 4
3, 4, or 8	(and) 3 or 8	= 5

STEP 2: If audited parenteral/IV and/or feeding tube, use chart below:

K5a = checked	ADL Score = 3	OR
K5b = checked + K6a = 3 or 4	ADL Score = 3	OR
K5b = checked + K6a = 2 AND K6b = 2, 3, 4, 5	ADL Score = 3	

STEP 3: Return to G1hA to calculate the eating score using the chart below:

Column A =	ADL score =
- , 0 or 1	= 1
2	= 2
3, 4, or 8	= 3

Interpretation for ADLs when code "8" is reviewed for validation purposes:

Addendum Items

- Example #1: When the FRN can clearly determine that the ADL did not occur for the entire 7-day observation period, a code "8" will be accepted. If the ADL did occur, the Self-Performance Tree on p. 3-90 of the MDS User's Manual will be utilized.

  For example: The ADL was captured on a flow sheet or ADL tracking form and coded "8" on days 1-4, blanks were observed on days 5 & 6, and day 7 was coded "4" (total dependence).

In the above scenario, the FRN would be unable to determine what happened on days 5 & 6. She cannot "assume" that the resident was totally dependent for care on the blank days, if no supporting documentation was found elsewhere in the chart. When looking at the Self-Performance Tree (p. 3-90), the only appropriate code, for validation purposes only, would be "0".

8 / 8 / 8 / 8 / blank / blank / 4 = 0 (For Validation Purposes Only)

The FRN must review supporting documentation (either on a flow sheet, ADL tracking form or narrative notes) in the clinical record to validate a "4" response (full staff performance every occurrence during the entire 7-day observation period). Therefore, for validation purposes only, the audit worksheet would be marked a "No" (documentation does NOT support transmitted value) and a comment shall be documented in the comment section for your review.

- Example #2: If an ADL was coded "8" for days 1-4, a "1" for day 5, a "2" for day 6, and a "3" for day 7, the appropriate response, for validation purposes only, would be a "1". In order to respond greater than a "1", according to the Self-Performance Tree on p. 3-90, the resident must have required some type of physical assistance at least 3 or more times during the 7-day observation period. Since day 5 was a "1" (supervision), the resident did not receive physical assistance 3 or more times in the scenario described.

8 / 8 / 8 / 8 / 1 / 2 / 3 = 1 (For Validation Purposes Only)

- Example #3: If an ADL was coded "8" for days 1-6 and a "4" on day 7, the appropriate response, for validation purposes only, would be "4". This would be because the only time the ADL occurred, the resident required total assistance ("4") and it would fall under the Self-Performance Tree scoring on p. 3-90 as "4" (full staff performance every occurrence during the entire 7-day observation period).

8 / 8 / 8 / 8 / 8 / 8 / 4 = 4 (For Validation Purposes Only)

Element Listing of RUG Items		
MDS 2.0 LOCATION	**FIELD DESCRIPTION**	**DOCUMENTATION GUIDELINES**
Section B	**Cognitive Patterns**	**Intent:** To determine the resident's ability to remember, think coherently, and organize daily self-care activities. These items are crucial factors in many care planning decisions. Your focus is on resident performance, including a demonstrated ability to remember recent and long-past events and to perform key decision-making skills. Questions about cognitive function and memory can be sensitive issues for some residents who may become defensive or agitated or very emotional. These are not uncommon reactions to performance anxiety and feelings of being exposed, embarrassed, or frustrated if the resident knows he or she cannot answer the questions cogently. Be sure to interview the resident in a private, quiet area without distractions – i.e., not in the presence of other residents or family, unless the resident is too agitated to be left alone. Using a nonjudgmental approach to questioning will help create a needed sense of trust between staff and resident. Be cognizant of possible cultural differences that may affect your perception of the resident's response. After eliciting the resident's responses to the questions, return to the resident's family or others, as appropriate, to clarify or validate information regarding the resident's cognitive function over the last 7 days. For residents with limited communication skills or who are best understood by family or specific caregivers, you will need to carefully consider their insights in this area. • Engage the resident in general conversation to help establish rapport. • Actively listen and observe for clues to help you structure your assessment. Remember – repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide important information about cognitive function. • Be open, supportive, and reassuring during your conversation with the resident (e.g., "Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you."). If the resident becomes really agitated, sympathetically respond to his or her feelings of agitation and STOP discussing cognitive function. The information-gathering process does not need to be completed in one sitting but may be ongoing during the entire assessment period. Say to the agitated resident, for example,

Section B **(7-day look back)**	**Cognitive Patterns** **p. 3-41 & 3-42**	"Let's talk about something else now," or "We don't need to talk about that now. We can do it later." Observe the resident's cognitive performance over the next few hours and days and come back to ask more questions when he or she is feeling more comfortable. It is often difficult to accurately assess cognitive function, or how someone is able to think, remember, and make decisions about their daily lives, when they are unable to verbally communicate with you. It is particularly difficult when the areas of cognitive function you want to assess require some kind of verbal response from the resident (e.g., memory recall). It is certainly easier to perform an evaluation when you can converse with a resident and hear responses from them that give you clues to how the resident is able to think (judgment), if he understands his strengths and weaknesses (insight), whether he is repetitive (memory), or if he has difficulty finding the right words to tell you what he wants to say (aphasia). To assess an aphasic resident, it is very important that you hone your listening and observation skills to look for non-verbal cues to the person's abilities. For example, for someone who is unable to speak with you but seems to understand what you are saying (expressive aphasia), the assessor could ask the resident the necessary questions and then ask him to answer you with whatever non-verbal means he is able to use (e.g., writing the answer; showing you the way to his room; pointing to a calendar to show you what month/season it is). Observe the resident at different times of the day and in different types of activities for clues to their functional abilities. Solicit input from the observations of others who care for the resident. In all cases, code the cognitive items with answers that reflect your best clinical judgment, realizing the difficulty in assessing residents who are unable to communicate. MDS Items B1, B4, B5 and B6 can be successfully coded without having to get verbal answers from the resident. Interdisciplinary collaboration will be helpful in conducting an accurate assessment.
B1	**Comatose** **Clarification:**	**Intent:** To record whether the resident's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state. ♦ Comatose (coma) is a pathological state in which neither arousal (wakefulness, alertness) nor awareness (cognition of self and environment) is present. The comatose person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak, and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).

B1 **(7-day look back)**	**Comatose Clarification:** **p. 3-42 & 3-43**	Sometimes residents who were comatose for a period of time after an anoxic-ischemic injury (i.e., not enough oxygen to the brain), from a cardiac arrest, head trauma or massive stroke, regain wakefulness but have no evidence of any purposeful behavior or cognition. Their eyes are open and they seem to be awake. They may grunt, yawn, pick with their fingers and have random movements of their heads and extremities. A neurological exam shows that they have extensive damage to both cerebral hemispheres. This state is different from coma, and if it continues, is called a persistent vegetative state. Both coma and vegetative state have serious consequences in terms of long-term clinical outcomes and care needs. Many other residents have severe impairments in cognition that are associated with late stages of progressive neurological disorders such as Alzheimer's disease. Although such residents may be non-communicative, totally dependent on others for care and nourishment, and sleep a great deal of time, they are usually not comatose or in a persistent vegetative state as described above. To prevent any resident from being mislabeled as such, it is imperative that coding of comatose reflects physician documentation of a diagnosis of either coma or persistent vegetative state. **A physician's documented neurological diagnosis of comatose (coma) or persistent vegetative state shall be present in the clinical record prior to the A3a date.**
B2 **B2a**	**Memory** **Short-Term Memory** **<u>Addendum Item</u>**	**Intent:** To determine the resident's functional capacity to remember both recent and long-past events (i.e., <u>short-term</u> and long-term memory). **Process:** Ask the resident to describe a recent event that both of you had the opportunity to remember. Or, you could use a more structured short-term memory test. For residents with limited communication skills, ask staff and family about the resident's memory status. Remember, if there is no positive indication of memory ability, (e.g., remembering multiple items over time or following through on a direction given 5 minutes earlier) the correct response is "1", Memory Problem. When a resident is cognitively impaired and/or uncooperative with the assessment process/interview, supporting documentation shall demonstrate how the resident's memory ability was determined (i.e., examples on p. 3-44) during the observation period that ends on the A3a date.

B2a **(7-day look back)**	**Short-Term Memory** **Clarifications:** **p. 3-43 & 3-45**	Examples: Ask the resident to describe the breakfast meal or an activity just completed. Ask the resident to remember three items (e.g., book, watch, table) for a few minutes. After you have stated all three items, ask the resident to repeat them to you (to verify that you were heard and understood). Then proceed to talk about something else – do not be silent, do not leave the room. In five minutes, ask the resident to repeat the name of each item. If the resident is unable to recall all three items, code "1". For persons with verbal communication deficits, non-verbal responses are acceptable (e.g., when asked how many children they have, they can tap out a response of the appropriate number). ♦ Many persons with memory problems can learn to function successfully in a structured, routine environment. Observing resident function in multiple daily activities is only one aspect of evaluating short-term memory function. For example, a resident may remember to come to lunch but may not remember what he/she ate. The short-term memory test described above is still an important component of the overall evaluation. ♦ When coding short-term memory, identify the most representative level of function, not the highest. Therefore, a resident with short-term memory problems 6 of the 7 days should be coded as "1". For many residents, performance varies. Staff must use clinical judgment to decide whether or not a single observation provides sufficient information on the resident's typical level of function**.** **Documentation of how the resident's short-term memory was determined shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
B4	**Cognitive Skills for Daily Decision-Making**	**Intent:** To record the resident's actual performance in making everyday decisions about tasks or activities of daily living. Examples: Choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary); making the correct decision concerning how to get to the lunchroom; acknowledging need to use a walker, and using it faithfully.

B4	**Cognitive Skills for Daily Decision-Making** **<u>Addendum Items</u>**	The Review Nurse(s) must see documentation of the resident's ACTUAL performance in making "everyday" decisions during the observation period that ends on the A3a date. It is NOT a requirement to have "daily" documentation of the decision-making but it is necessary to document the resident's ACTUAL performance (i.e., examples on p. 3-46 & 3-47 of the MDS User's Manual). A check off sheet would be acceptable (for validation purposes) IF examples were included using MDS language. A statement that says, "Cognition is severely impaired" is NOT acceptable because it does not give examples per Task Force. **Process:** Review the clinical record. Consult family and nurse assistants. Observe the resident. The inquiry should focus on whether or not the resident is actively making these decisions, and not whether staff believes the resident might be capable of doing so or not. Remember the intent of this item is to record what the resident is doing (performance). Where a staff member takes decision-making responsibility away from the resident regarding tasks of everyday living, or the resident does not participate in decision-making, whatever his or her level of capability may be, the resident should be considered to have impaired performance in decision-making. This item is especially important for further assessment and care planning in that it can alert staff to a mismatch between a resident's abilities and his or her current level of performance, or that staff may be inadvertently fostering the resident's dependence.
	Clarifications:	• If the resident "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, Item B4 would be coded as "3" for Severely Impaired. If the resident attempts to make decisions, although poorly, code "2" for Moderately Impaired. • Coding the following examples for MDS Item B4, "Cognitive Skills for Daily Decision-Making:" 1. If a resident seems to have severe cognitive impairment and is non-verbal, but usually clamps his or her mouth shut when offered a bite of food, would the resident be considered moderately or severely impaired? 2. If a resident does not generally make conversation or make his or her needs known, but replies "yes" when asked if he or she would like to take a nap, would the resident be considered moderately or severely impaired?

B4 **(7-day look back)**	**Cognitive Skills for Daily Decision-Making Clarifications:** **p. 3-46 & 3-47**	These examples are similar in that the residents are primarily non-verbal and do not make their needs known, but they do make basic verbal or non-verbal responses to simple gestures or questions regarding care routines (e.g., comfort). More information about how the resident functions in his or her environment is needed to definitively answer the questions. From the limited information provided about these residents, one would gather that their communication is only focused on very particular circumstances, in which case it would be regarded as "rarely/never" in the relative number of decisions a person could make during the course of a week, and MDS Item B4 would be coded as "3", Severe Impairment. The assessor should determine if the resident would respond in a similar fashion to other requests made during the 7-day observation period. If such "decisions" are more frequent, the resident may be only moderately impaired or better. **Documentation of the resident's actual performance in making everyday decisions shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
Section C **C4**	**Communication/ Hearing Patterns** **p. 3-51** **Making Self Understood**	**Intent:** To document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others. There are many possible causes for the communication problems experienced by elderly nursing facility residents. Some can be attributed to the aging process; others are associated with progressive physical and neurological disorders. Usually the communication problem is caused by more than one factor. For example, a resident might have aphasia as well as long standing hearing loss; or he or she might have dementia and word finding difficulties and a hearing loss. The resident's physical, emotional and social situation may also complicate communication problems. Additionally, a noisy or isolating environment can inhibit opportunities for effective communication. Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions. Deficits in ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing and gesturing. **Intent:** To document the resident's ability to express or communicate requests, needs, opinions, urgent problems and social conversation, whether in speech, writing, sign language, or a combination of these.

C4 **(7-day look back)**	**Making Self Understood** **<u>Addendum Item</u>** **Clarification:** **p. 3-52 & 3-53**	**Process:** Interact with the resident. Observe and listen to the resident's efforts to communicate with you. Observe his or her interactions with others in different settings (e.g., one-on-one, groups) and different circumstances (e.g., when calm, when agitated). Consult with the primary nurse assistant (over all shifts), if available, the resident's family, and speech-language pathologists. "A check off sheet would be acceptable IF it includes the MDS User's Manual definition of each area OR an example that fits the definition AND occurs during the 7-day observation period that ends on the A3a date." ♦ A resident assessed in Item C4 (Making Self Understood) as "3" (Rarely/Never Understood) should not necessarily be coded as severely impaired in daily decision-making (Item B4, Cognitive Skills). The two areas of function are not always associated. The ability to understand may not be a functional problem, but a different language spoken by the resident. For example, a person who rarely/never understands may speak a language other than that spoken by caregivers, or he/she may be profoundly hearing or vision impaired. A more thorough assessment must be done to determine the actual level of cognitive function. **Documentation of actual ways the resident makes himself or herself understood shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
Section E	**Mood and Behavior Patterns**	Mood distress is a serious condition and is associated with significant morbidity. Associated factors include poor adjustment to the nursing facility, functional impairment, resistance to daily care, inability to participate in activities, isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain. It is particularly important to identify signs and symptoms of mood distress among elderly nursing facility residents because they are very treatable. In many facilities, staff has not received specific training in how to evaluate residents who have distressed mood or behavioral symptoms. Therefore, many problems are under diagnosed and under treated. In facilities where such training has not occurred, an in-service program under the direction of a professional mental health specialist is recommended. At a minimum, staff in such facilities has found the various mental health RAPs (e.g., Mood, Behavior) to be helpful and these should be carefully reviewed. The process for gathering information should include direct observation of the resident, communication with the resident's direct caregivers across all shifts, review of relevant information

Section E	**Mood and Behavior Patterns** **p. 3-60 & 3-61**	in the resident's clinical record, and if possible, consultation with family members or friends who have a direct knowledge of the resident's behavior in the observation period. If the person completing the MDS did not observe the behavior but others report that it occurred, the behavior must be considered as having occurred and should be so documented. It is important to document chronic symptoms as well as new onset. As always, the medical record should support the resident's status as reported on the MDS. It is important to note that coding the presence of indicators in Section E does not automatically mean that the resident has a diagnosis of depression or anxiety. Assessors do not make or assign a diagnosis in Section E; they simply record the presence or absence of specific indicators and behaviors. It's important that facility staff recognizes these clinical indicators and consider them when developing the resident's care plan.
E1a-p	**Indicators of Depression, Anxiety, Sad Mood** **<u>Addendum Item</u>**	**Intent:** To record the frequency of indicators observed in the last 30 days, irrespective of the assumed cause of the indicator (behavior). **Definition:** Feelings of distress may be expressed directly by the resident who is depressed, anxious or sad. However, statements such as "I'm so depressed" are rare in the older nursing facility population. Rather, distress is more commonly expressed in the following ways: A check form or flow sheet indicating the frequency and type of behavior is acceptable during the observation period that ends on the A3a date. An entry in the clinical record on a per occurrence basis is also acceptable for consideration of validation. However, a summary alone is NOT acceptable because they are too general and do not capture the information needed. VERBAL EXPRESSIONS OF DISTRESS **a. Resident Made Negative Statements –** e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die." **b. Repetitive Questions –** e.g., "Where do I go; What do I do?" **c. Repetitive Verbalizations –** e.g., Calling Out for help, ("God help me"). **d. Persistent Anger with Self or Others –** e.g., easily annoyed, anger at placement in nursing facility, anger at care received. **e. Self-Deprecation –** e.g., "I am nothing; I am of no use to anyone".

E1a-p	**Indicators of Depression, Anxiety, Sad Mood**	**f. Expressions of What Appear to Be Unrealistic Fears –** e.g., fear of being abandoned, left alone, being with others. **g. Recurrent Statements that Something Terrible is About to Happen –** e.g., believes he or she is about to die, have a heart attack. **h. Repetitive Health Complaints –** e.g., persistently seeks medical attention, obsessive concern with body functions. **i. Repetitive Anxious Complaints/concerns (non-health related) –** e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, and relationship issues. DISTRESS MAY ALSO BE EXPRESSED NON-VERBALLY AND IDENTIFIED THROUGH OBSERVATION OF THE RESIDENT IN THE FOLLOWING AREAS DURING USUAL DAILY ROUTINES: SLEEP CYCLE ISSUES – Distress can also be manifested through disturbed sleep patterns. **j. Unpleasant Mood in Morning –** e.g., angry, irritable. **k. Insomnia/Change in Usual Sleep Pattern –** e.g., difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep. SAD, APATHETIC, ANXIOUS APPEARANCE **l. Sad, Pained, Worried Facial Expressions –** e.g., furrowed brows. **m. Crying, tearfulness** **n. Repetitive Physical Movements –** e.g., pacing, hand wringing, restlessness, fidgeting, picking. LOSS OF INTEREST – These items refer to a change in resident's usual pattern of behavior. **o. Withdrawal from Activities of Interest –** e.g., no interest in long standing activities or being with family/friends. If the resident's withdrawal from activities of interest persists over time, it should continue to be coded, regardless of the amount of time the resident has withdrawn from activities of interest or has shown no interest in being with family/friends. **p. Reduced Social Interaction –** e.g., less talkative, more isolated.

E1a-p	**Indicators of Depression, Anxiety, Sad Mood**	**Process:** Initiate a conversation with the resident. Some residents are more verbal about their feelings than others and will either tell someone about their distress, or tell someone only when directly asked how they feel. Other residents may be unable to articulate their feelings (i.e., cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe residents carefully for any indicator. Consult with direct-care staff over all shifts, if possible and family who have direct knowledge of the resident's behavior. Relevant information may also be found in the clinical record.
	Clarifications:	♦ The keys to obtaining, tracking and recording accurate information in Item E1, (Indicators of Depression) are: 1) interviews with and observations of residents, and 2) communication between licensed and non-licensed staff and other caregivers. • Daily communication between nurses, nurse assistants and other direct-care providers is crucial for resident monitoring and care giving. • Educate all caregivers (including direct care staff and staff who routinely come into contact with residents, such as housekeepers, maintenance, and dietary personnel) about the residents' status in this area, and how to observe mood and behavior patterns that are captured in MDS Item E1. These mood and behavior patterns are not part of normal aging. They are often indicative of depression, anxiety, and other mental disorders. These conditions are often under-identified and under-treated or untreated. Part of the reason may be that over time, these symptoms tend to be perceived as the residents' "normal" or "usual" behaviors. • Documentation of signs and symptoms of depression, anxiety and sad mood, and of behavioral symptoms, is a matter of good clinical practice. This information facilitates accurate diagnosis and identification of new or worsening problems. It should be used in identification of new or worsening problems. This information facilitates communication to the entire treatment team, across shifts, and is necessary in order to monitor, on an on-going basis, the resident's status and response to treatment. It is up to the facility to determine the form and format of such documentation. ♦ The mood items specify a 30-day observation period. Try a rule-out process to make coding easier. For each indicator listed, think about whether or not it occurred at all. If not, use code "0". If the resident exhibited the behavior almost daily (6 or 7 days a week), or multiple times daily, code "2". If codes "0" or "2" do not reflect the resident's status, but the behavior occurred at least once, use code "1".

E1a-p **(30-day look back)**	**Indicators of Depression, Anxiety, Sad Mood Clarifications:** **p. 3-61 to 3-64**	♦ If an indicator of depression occurs twice in the last 30 days (not 2 times each week), it should be coded as "1" to indicate that the indicator of depression was exhibited up to 5 days a week (but less than 6 days a week). It does not need to occur in each week to be coded. If an indicator of depression occurs only in the beginning of the 30-day period, it should be coded as an indicator of depression occurring up to 5 days a week (but less than 6 days a week) in the last 30 days. Example: Mr. F is a new admission that becomes upset and angry when his daughter visits (3 times a week). He complains to her and staff caregivers that 'she put me in this terrible dump.' He chastises her 'for not taking him into her home,' and berates her 'for being an ungrateful daughter.' After she leaves, he becomes remorseful, sad looking, tearful, and says, "What's the use. I'm no good. I wish I died when my wife did." Coding "1" for a. (Resident made negative statements), d. (Persistent anger with self or others), e. (Self-deprecation), m. (Crying, tearfulness), remaining Mood items would be coded "0". **Documentation of the frequency of indicators (behaviors) shall be present in the clinical record during the 30-day observation period that ends on the A3a date.**
E4	**Behavioral Symptoms**	**Intent:** To identify (A) the frequency, and (B) the alterability of behavioral symptoms in the last 7 days that cause distress to the resident, or are distressing or disruptive to facility residents or staff members. Such behaviors include those that are potentially harmful to the resident himself or herself or disruptive in the environment, even if staff and other residents appear to have adjusted to them (e.g., "Mrs. R's calling out isn't much different than others on the unit. There are many noisy residents;" or "Mrs. L doesn't mean to hit me. She does it because she's confused.") Acknowledging and documenting the resident's behavioral symptom patterns on the MDS provide a basis for further evaluation, care planning and delivery of consistent, appropriate care towards ameliorating the behavioral symptoms. Documentation in the clinical record of the resident's current status may not initially be detailed (and in some cases will not pinpoint the resident's actual problems) and it is not intended to be the one and only source of information. (See Process below). However, once the frequency and alterability of behavioral symptoms is accurately determined, subsequent documentation should more accurately reflect the resident's status and response to interventions.

E4	**Behavioral Symptoms** **Addendum Item**	A check form or flow sheet indicating the frequency and type of behavior is acceptable during the observation period that ends on the A3a date. An entry in the clinical record on a per occurrence basis is also acceptable for consideration of validation. However, a summary alone is NOT acceptable because they are too general and do not capture the information needed. Supporting documentation for behavior (E4) shall identify specific dates of occurrences in order to determine how many times a specific behavior occurred during the 7-day observation period that ends on the A3a date. **Definition:**
E4a	**Wandering**	**a.** Locomotion with no discernible, rational purpose. A wandering resident may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair. Do not include pacing as wandering behavior. Pacing back and forth is not considered wandering, and if it occurs, it should be documented in Item E1n, "Repetitive Physical Movements".
E4b	**Verbally Abusive**	**b.** Other residents or staff were threatened, screamed at, or cursed at.
E4c	**Physically Abusive**	**c.** Other residents or staff were hit, shoved, scratched, or sexually abused.
E4d	**Socially Inappropriate/ Disruptive**	**d.** Includes disruptive sounds, excessive noise, screams, self-abusive acts, or sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings.
E4e	**Resists Care**	**e.** Resists taking medications/injections, ADL assistance or help with eating. This category does NOT include instances where the resident has made an informed choice not to follow a course of care (e.g., resident has exercised his or her right to refuse treatment, and reacts negatively as staff try to reinstitute treatment). Signs of resistance may be verbal and/or physical (e.g., verbally refusing care, pushing caregiver away, and scratching caregiver). These behaviors are not necessarily positive or negative, but are intended to provide information about the resident's responses to nursing interventions and to prompt further investigation of causes for care planning purposes (e.g., fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

E4 **(7-day look back)**	**Behavioral Symptoms** **p. 3-66 & 3-67**	**Process:** Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's action, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to start the assessment by recording any behavioral symptoms. The fact that staff has become used to the behavior and minimize the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioral symptom or not? Is the resident combative during personal care and strike out at staff or not? Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to him or her. Consult with staff that provides direct care on all three shifts. A symptomatic behavior can be present and the RN Assessment Coordinator might not see it because it occurs during intimate care on another shift. Therefore, it is especially important that input from all nurse assistants having contact with the resident be solicited. Also, be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the unit norm (e.g., staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.). Focus staff attention on what has been the individual resident's actual behavior over the last 7 days**.** Finally, although it may not be complete, review the clinical record for documentation. **Documentation of the individual resident's actual behavior shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
Section H **H3a**	**Continence in Last 14 Days** **Any Scheduled Toileting Plan** ***CMS Update**	**H3 Appliances and Programs** **Definition:** **a.** A plan <u>for bowel and/or bladder elimination</u> whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes habit training and/or prompted voiding.

H3a		**MDS Tip Sheet: ITEM H3a** ***Any Scheduled Toileting Plan* MAY 2008**
	INTRODUCTION	In response to questions related to MDS coding for item H3a, scheduled toileting plan, the following tip sheet has been developed. Use this MDS 2.0 Tip Sheet to better understand MDS coding rationale for this item.
	DEFINITION	Item H3a asks you to indicate whether the resident is on a plan for bowel and/or bladder elimination whereby staff members, at scheduled times each day, either take the resident to the toilet room, give the resident a urinal, or remind the resident to go to the toilet during the 14-day observation period. This item includes bowel habit training and/or prompted voiding.
	CLARIFICATIONS	There are **three key concepts** to consider when coding item H3a: **Scheduled** – means performing the activity according to a specific, routine time that has clearly been communicated to the resident (as appropriate) and to caregivers. **Toileting** – means voiding in a bathroom, commode or other appropriate receptacle (e.g. urinal, bedpan). **Plan/Program** – means a specific approach that is *organized, planned, documented, monitored and evaluated.* ***All three (3) key components must be present in order to code H3a.***
	CODING TIPS	Simply providing incontinence care for a resident does not mean that the resident is on a Toileting Plan. The plan must be based on the ***individualized*** assessment of the resident's need for a toileting program. Consider the following items when evaluating whether a scheduled toileting plan/program may be coded at H3a: 1. The plan should contain an **individualized, resident-specific** toileting schedule – listed either by hours or around the resident's pattern. [**Note**: This does not include generic, every two-hour toileting; nor does it include a plan/schedule that is the same for all incontinent residents.] 2. The **resident's individualized plan** should be clearly communicated and be available and accessible to staff and the resident (as appropriate), via the resident care plan, flow records, verbal and written report, etc. 3. The **resident's response** to the toileting program and subsequent evaluation should be documented in the clinical record and include when changes have been made, depending on the resident's response.

H3a	**CODING TIPS**	4. If the resident is coded a "4" (totally incontinent) in item H1, then clinical documentation would need to be present to support the appropriateness of coding item H3a.
	CODING EXAMPLES	1) Mr. M., who has a diagnosis of CHF and a history of left-sided hemiplegia from a previous stroke, has had an increase in urinary incontinence. The team has assessed him for a reversible cause of the incontinence and has evaluated his voiding pattern using a voiding **assessment**. After completing this assessment, a plan was developed that called for toileting every hour for four hours after receiving his diuretic, then every three hours until bedtime. The team has communicated this approach to the resident and the care team and has placed these interventions in the care plan. The team will re-evaluate the resident's response to the plan after one month and adjust as needed. This is a scheduled toileting plan. **Code item H3a.** 2) Mrs. H. has a diagnosis of advanced Alzheimer's disease. She is dependent on the staff for her ADLs, does not have the cognitive ability to void in the toilet or other appropriate receptacle, and is totally incontinent. Her voiding **assessment** indicates no pattern to her incontinence. Her care plan states that due to her total incontinence, staff should follow the facility standard policy for incontinence, which is to check and change every two hours while awake and apply a super absorbent brief at bedtime so as not to disturb her sleep. This is not a scheduled toileting plan. **Do NOT code item H3a.**
	FOR MORE HELP	The RAI User's Manual for MDS coding is available on the Centers for Medicare & Medicaid website: http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp. If you need help interpreting MDS coding instructions, contact your State RAI/MDS Coordinator listed in Appendix B of the User's Manual. If you require further assistance, you may submit your question to: mdsquestions@cms.hhs.gov.
	Addendum Items	• Any scheduled toileting plan "refers to a specific approach that is organized, planned, documented, monitored and evaluated. Documentation in the clinical record should evaluate the resident's response to the toileting program." (Refer to clarification in the MDS 2.0 User's Manual, p. 3-125.) • Nurse Aide Care Plans are acceptable to support turning/repositioning and scheduled toileting plans for audit/review purposes.

H3b	**Bladder Retraining Program**	**b.** A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability. **Process:** Check the clinical record. Consult with nurse assistant and the resident. Be sure to ask about any items that are hidden from view because they are worn under clothing (e.g., pads or briefs).
	Toileting Program Clarifications:	• There are 3 key ideas captured in Item H3a: 1) scheduled, 2) toileting, and 3) program. The word "scheduled" refers to performing the activity according to a specific, routine time that has been clearly communicated to the resident (as appropriate) and caregivers. The concept of "toileting" refers to voiding in a bathroom or commode, or voiding into another appropriate receptacle (i.e., urinal, bedpan). Changing wet garments is not included in this concept. A "program" refers to a specific approach that is organized, planned, documented, monitored and evaluated. A scheduled toileting program could include taking the resident to the toilet, providing a bedpan at scheduled times, or verbally prompting to void. • If the scheduled plan is recorded in the care plan and staff are actually toileting the resident according to the multiple specified times, check Item H3a. If the resident also experiences breakthrough incontinence, this would be a good time to reevaluate the effectiveness of the current plan by assessing if the resident has a new, reversible condition causing a decline in continence (e.g., UTI, mobility problem, etc.), and treating the underlying cause. Also determine whether or not there is a pattern to the extra times the resident is incontinent and consider adjusting the scheduled toileting plan accordingly. • For residents on a scheduled toileting plan, the care plan should at least note that the resident is on a routine toileting schedule. A resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff. If the care plan is the resource used by staff to be made aware of resident's specific toileting schedules, then the toileting schedule should appear there. Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each day. If the timing of such routines is not fairly standardized, specific times
	Toileting Program	

H3b **14-day look back)**	**Clarifications:** **p. 3-124 & 3-125**	should then be noted. Documentation in the clinical record should evaluate the resident's response to the toileting program. • Feeding tubes/gastrostomies are coded in Sections K and P. Only appliances used for elimination are coded here. **Documentation of the resident's scheduled toileting plan or bladder retraining program and the resident's response to the either program shall be present in the clinical record during the 14-day observation period that ends on the A3a date.**
Section I	**Disease Diagnoses** **p. 3-127**	**Intent:** To code those diseases or infections which have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. In general, these are conditions that drive the current care plan. • The disease conditions in this section require a physician-documented diagnosis in the clinical record. It is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis. • Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan. In many facilities, clinical staff and physicians neglect to update the list of resident's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the resident's plan of care. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status. **Definition: Nursing Monitoring –** Includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)
I1	**Diseases**	Check condition only if the resident's condition meets the description in I1. **Definition:** **a. Diabetes Mellitus –** Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).

I1	**Diseases**	**r. Aphasia –** A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language. Include aphasia due to CVA. **s. Cerebral Palsy –** Paralysis related to developmental brain defects or birth trauma. Includes spastic quadriplegia secondary to cerebral palsy. **v. Hemiplegia/Hemiparesis –** Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism or tumor. **w. Multiple Sclerosis –** Chronic disease affecting the central nervous system with remissions and relapses of weakness, incoordination, paresthesis, speech disturbances and visual disturbances. **z. Quadriplegia –** Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. (Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia.) Do not code quadriparesis here.
	Addendum Item	Supporting documentation for diseases would need to: 1) demonstrate that the disease was being treated OR 2) has an impact on their daily care during the 7-day observation period that ends on the A3a date. **Process:** Consult transfer documentation and medical record (including current physician treatment orders and nursing care plans). If the resident was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD-9-CM codes that were current during the hospital stay. If these diagnoses are still active, record them on the MDS form. Also accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation. A physician diagnosis is required to code the MDS. Check a disease item only if the disease has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, it is not necessary to check “hypertension” if one episode occurred several years ago unless the hypertension is either currently being controlled with medications, diet, biofeedback, etc., or is being regularly monitored to prevent a recurrence. Physician involvement in this part of the assessment process is crucial. The physician should be asked to review the items in Section I, close to the scheduled MDS. Use this scheduled visit as an opportunity to ensure that active diagnoses are noted and “inactive” diagnoses are designated as resolved. This is also an
I1	**Diseases**	

(7-day look back)	**p. 3-127 to 3-131**	important opportunity to share the entire MDS assessment with the physician. In many nursing facilities, physicians are not brought into the MDS review and assessment process. It is the responsibility of facility staff to aggressively solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, you should share this section of the MDS with the physician and ask for his or her input. Physicians completing a portion of the MDS assessment should sign in Item AA9 (Signatures of Those Completing the Assessment). Full physician review of the most recent MDS assessment or ongoing input into the assessment currently being complete can be very useful. For the physician, the MDS assessment completed by facility staff can provide insights that would have otherwise not been possible. For staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional follow-up. **A physician-documented diagnosis(es) shall be present in the clinical record prior to the A3a date. Supporting documentation that the disease is identified and being treated during the 7-day observation period that ends on the A3a date shall be present in the clinical record.**
I2	**Infections** **<u>Addendum Item</u>**	**Definition:** **e. Pneumonia –** Inflammation of the lungs; most commonly of bacterial or viral origin. **g. Septicemia -** Morbid condition associated with bacterial growth in the blood. Septicemia can be indicated once a blood culture has been ordered and drawn. A physician's working diagnosis of septicemia can be accepted, provided the physician has documented the septicemia diagnosis in the resident's clinical record. Supporting documentation for infections would need to: 1) demonstrate that the infection was being treated OR 2) has an impact on their daily care during the 7-day observation period that ends on the A3a date. **Process:** Consult transfer documentation and the resident's clinical record (including current physician treatment orders and nursing care plans). Accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation. A physician diagnosis is required to code the MDS. Physician involvement in this part of the assessment process is crucial.

I2 **(7-day look back)**	**Infections** **p. 3-135 & 3-136**	**A physician-documented diagnosis (es) shall be present in the clinical record prior to the A3a date. Supporting documentation that the infection is identified and being treated during the 7-day observation period that ends on the A3a date shall be present in the clinical record.**
Section J	**Health Conditions**	
J1	**Problem Conditions**	To record specific problems or symptoms that affect or could affect the resident's health or functional status, and to identify risk factors for illness, accident, and functional decline. **INDICATORS OF FLUID STATUS** **Definition:**
J1c	**Dehydrated; Output Exceeds Intake**	**c. Dehydrated; Output Exceeds Intake –** Check this item if the resident has 2 or more of the following indicators: **1.** Resident usually takes in less than the recommended 1500 ml of fluids daily (water or liquids in beverages and water in high fluid content foods such as gelatin and soups). Note: The recommended intake level has been changed from 2500 ml to 1500 ml to reflect current practice standards**.** 2. Resident has one or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium albumin, blood urea nitrogen, or urine specific gravity). **3.** Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).
J1e	**Delusions**	**e. Delusions –** Fixed, false beliefs not shared by others that the resident holds even when there is obvious proof or evidence to the contrary (e.g., belief he or she is terminally ill; belief that spouse is having an affair; belief that food served by the facility is poisoned).
J1h	**Fever**	**h. Fever –** A fever is present when the resident's temperature (Fahrenheit) is 2.4 degrees greater than the baseline temperature. The baseline temperature may have been established prior to the Assessment Reference Date.

J1H	**Fever** **<u>Addendum Item</u>**	Supporting documentation for fever must: 1) clearly identify a "baseline temperature" OR 2) state how the baseline temperature was determined. Documentation shall support that the resident's temperature (Fahrenheit) is 2.4 degrees greater than the baseline temperature during the 7-day observation period that ends on the A3a date.
J1i	**Hallucinations**	**i. Hallucinations -** False sensory perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people, animals), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes).
J1j	**Internal Bleeding**	**j. Internal Bleeding –** Bleeding may be frank (such as bright Red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds", hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nosebleeds that are easily controlled should not be coded as internal bleeding.
J1o	**Vomiting**	**o. Vomiting -** Regurgitation of stomach contents; may be caused by any etiology (e.g., drug toxicity; influenza; psychogenic). **Process:** It is often difficult to recognize when a frail, chronically ill elder is experiencing dehydration or, alternatively, fluid overload that could precipitate congestive heart failure. Ways to monitor the problem, particularly in residents who are unable to recognize or report the common symptoms of fluid variation, are as follows: Ask the resident if he or she has experienced any of the listed symptoms in the last 7 days. Review the clinical records (including current nursing care plan) and consult with facility staff members and the resident's family if the resident is unable to respond. A resident may not complain to staff members or others, attributing such symptoms to "old age." Therefore, it is important to ask and observe the resident, directly if possible, since the health problems being experienced by the resident can often be remedied.
J1 **7-day look back)**	**Problem Conditions** **p. 3-138 to 3-140**	**Documentation of specific occurrences of dehydration, delusions, fever, hallucinations, internal bleeding, vomiting shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**

Section K	**Oral/Nutritional Status** **p. 3-149**	Residents in nursing facilities challenge the staff with many conditions that could affect their ability to consume food and fluids to maintain adequate nutrition and hydration. Early problem recognition can help to ensure appropriate and timely nutritional intervention. Prevention is the goal, and early detection and modification of interventions is the key. Section K, Oral and Nutritional Status, should assist the nursing facility staff in recognizing nutritional deficits that will need to be addressed in a resident's care plan. Nurse assessors will need to collaborate with the dietitian and dietary staff to ensure that some items in this section have been assessed and calculated accurately. Keep in mind that Section 1.13 states that the RAI must be conducted or coordinated with the appropriate participation of health professionals…facilities have flexibility in determining who should participate in the assessment process, as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment.
K3	**Weight Change**	**Intent:** To record variations in the resident's weight over time.
K3a	**Weight Loss**	**Definition: Weight Loss in Percentages** (e.g., 5% or more in last 30 days, or 10% or more in last 180 days). **Process: New Admission –** Ask the resident or family about weight changes over the last 30 and 180 days**.** Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods. **Current Resident –** Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight loss in percentages during the specified time periods.
	Clarifications:	• The first step in calculating percent weight gain or loss is to obtain the weights for the 30-day and 180-day time periods from the resident's clinical record. The calculation is as follows: 1. Start with the resident's weight from 30 days ago and multiply it by the proportion (0.05). If the resident has gained or lost more than this 5%, code a "1" for Yes. 2. Start with the resident's weight from 180 days ago
K3a	**Weight Loss**	

	Clarifications:	and multiply it by the proportion (0.10). If the resident has gained or lost more than this 10% code a "1" for Yes. 3. Residents experiencing a 7.5% weight change (gain or loss) 90 days ago must be evaluated to determine how much of the 7.5% weight change occurred over the last 30 days.
	CMS Update	• MDS coding for items K3a and K3b captures the resident's weight at the 30-day and 180-day points. K3a and K3b capture the resident's weight at these two distinct points in time only and note if there has been a weight loss or gain in either of those time periods. • There are no specific regulations that address the desirable weight and time frames for weight gain or weight loss. However, there is some general information in the interpretive guidelines and in the Nutritional RAP that may provide guidance in this area. The amount of weight gain or loss is reflective of individual differences. Guidelines related to acceptable parameters of weight gain and loss are addressed in the OBRA regulations at 42 CFR 483.25, nutrition (F325 and F326) and 483.20(b) 2(xi), resident assessment nutritional status and requirements (F272), which corresponds to the MDS 2.0 Section K, Oral/Nutritional Status. The parameters for weight loss identified in the guidelines referenced above are: 1 month 5% significant >5% severe 3 months 7.5% significant >7.5% severe 6 months 10% significant >10% severe The measurement of weight is a guide in determining nutritional status. Therefore, the evaluation of the significance of weight gain or loss over a specific time frame is a crucial part of the assessment process. However, if the resident is losing/gaining a significant amount of weight, the facility should not wait for the 30 or 180-day timeframe to address the problem. Weight changes of 5% in one month, 7.5% in three months, or 10% in six months should prompt a thorough assessment of the resident's nutritional status. An adequate assessment should result in a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's needs and expressed desires.
K3a		

(30 to180-day look back)	**Weight Loss** **p. 3-150 to 3-152**	**Documentation with calculated weight loss in percentages shall be present in the clinical record during the 30-180 day observation period that ends on the A3a date.**
K5 **K5a** **(7-day look back)**	**Nutritional Approaches** **Parenteral/IV** **p. 3-153**	**Definition:** Include only fluids administered for nutrition or hydration, such as: • IV fluids or hyper-alimentation, including total parenteral nutrition (TPN), administered continuously or intermittently • IV fluids running at KVO (Keep Vein Open) • IV fluids administered via heparin locks • IV fluids contained in IV piggybacks • IV fluids used to reconstitute medications for IV administration DO NOT INCLUDE: • IV medications • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay • IV fluids administered solely as flushes • Parenteral/IV fluids administered during chemotherapy or dialysis For coding IV medications, see p. 3-182. **Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**

K5b	**Feeding Tube**	**Definition:** Presence of any type of tube that can deliver food/ nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tube.
	Clarification:	♦ If the resident receives fluids by hypodermoclysis and subcutaneous ports in hydration therapy, code these nutritional approaches in this item. The term parenteral therapy means "introduction of a substance (especially nutritive material) into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous)." If the resident receives fluids via these modalities, also code Items K6a and K6b, which refer to the caloric and fluid intake the resident received in the last 7 days. Additives such as electrolytes and insulin which are added to the resident's TPN or IV fluids should be counted as medications and documented in Section O1, Number of Medications, AND P1ac, IV Medications.
(7-day look back)	**p. 3-153 & 3-154**	**Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
K6	**Parenteral or Enteral Intake**	**Intent:** To record the proportion of calories received and the average fluid intake, through parenteral or tube feeding in the last 7 days.
K6a	**Proportion of Total Calories**	**Definition:** The proportion of all calories ingested during the last 7 days that the resident actually received (not ordered) by parenteral or tube feedings. Determined by calorie count. **Process:** Review Intake record. If the resident took no food or fluids by mouth, or took just sips of fluid, stop here and code "4" (76%-100%). If the resident had more substantial oral intake than this, consult with the dietitian who can derive a calorie count received from parenteral or tube feedings.
	<u>Addendum Items</u>	A resident receiving intake by mouth and tube feeding MUST have a calorie count for <u>BOTH the intake by mouth AND the tube feeding</u> in order to determine the proportion ratio of total calorie intake during the observation period that ends on the A3a date. (i.e., example on p. 3.155). When a resident is receiving IV fluids of D 5 1/2 solution for dehydration, the glucose provided in the IV would NOT be coded under Medications. Since the glucose is most likely being given for caloric value, the facility should code K6a for total calories received during the observation period that ends on the A3a date. However, if the glucose were being given to maintain sugar levels for a diabetic, it would be coded under IV medications.

<table>
<tr>
<td>K6a

7-day look back)</td>
<td>Proportion of Total Calories

p. 3-155 & 156</td>
<td>Example of Calculation for Proportion of Total Calories from IV or Tube Feeding

Mr. H has had a feeding tube since his surgery. He is currently more alert and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth but only in small to medium amounts. For the past week, he has been receiving tube feedings for nutritional supplementation. As his oral intake improves, the amount received by tube will decrease. The dietitian has totaled his calories per day as follows:

<table>
<tr><td>Step #1:</td><td></td><td>Oral</td><td></td><td>Tube</td></tr>
<tr><td></td><td>Sun.</td><td>500</td><td>+</td><td>2000</td></tr>
<tr><td></td><td>Mon.</td><td>250</td><td>+</td><td>2250</td></tr>
<tr><td></td><td>Tues.</td><td>250</td><td>+</td><td>2250</td></tr>
<tr><td></td><td>Wed.</td><td>350</td><td>+</td><td>2250</td></tr>
<tr><td></td><td>Thurs.</td><td>500</td><td>+</td><td>2000</td></tr>
<tr><td></td><td>Fri.</td><td>800</td><td>+</td><td>800</td></tr>
<tr><td></td><td><u>Sat.</u></td><td><u>800</u></td><td>+</td><td><u>1800</u></td></tr>
<tr><td></td><td>TOTAL</td><td>3450</td><td></td><td>14350</td></tr>
</table>

Step #2: Total calories = 3450 + 14350 = 17800

Step #3: Calculate percentage of total calories by tube feeding.

14350/17800 = .806 X 100 = 80.6%

Step #4: Code “4” for 76% to 100%

Documentation of the proportion of all calories ingested that the resident actually received (not ordered) by parenteral or tube feedings shall be present in the clinical record during the 7-day observation period that ends on the A3a date.</td>
</tr>
<tr>
<td>K6b</td>
<td>Average Fluid Intake</td>
<td>Definition: Average fluid intake per day by IV or tube feeding in last 7 days refers to the actual amount of fluid the resident received by these modes (not the amount ordered).

Process: Review the Intake and Output record from the last 7 days. Add up the total amount of fluid received each day by IV and/or tube feedings only. Also include the water used to flush as well as the “free water” in the tube feeding (based upon the percent of water in the specific enteral formula). The amount of heparinized saline solution used to flush a heparin lock is NOT included in the average fluid intake calculation, while the amount of fluid in an IV piggyback solution <u>is</u> included in the calculation. Divide the week’s total fluid intake by 7. This will give you the average of fluid intake per day.</td>
</tr>
</table>

K6b **(7-day look back)**	**Average Fluid Intake** **Clarifications:** **p. 3-156 to 3-158**	Example of Calculation for Average Daily Fluid Intake Mrs. A has swallowing difficulties secondary to Huntington's disease. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration. She received the following daily fluid totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days. Step #1: Sun. 1250 cc Mon. 775 cc Tues. 925 cc Wed. 1200 cc Thurs. 1200 cc Fri. 1200 cc Sat. 1000 cc TOTAL 7550 cc Step #2: 7550 divided by 7 = 1078.6 cc Step #3: Code "3" for 1001 to 1500 cc/day ♦ The basic TPN solution itself (that is, the protein/carbohydrate mixture or a fat emulsion) is not counted as a medication. The use of TPN is coded in Item K6a. When medications such as electrolytes, vitamins, or insulin have been added to the TPN solution, they are considered medications and should be coded in O1. ♦ The amount of heparinized saline solution used to flush a heparin lock is not included in the average fluid intake calculation. The amount of fluid in an IV piggyback solution is included in the calculation. **Documentation of the actual amount of fluid received (not the amount ordered) by IV and/or tube feedings only during the 7-day observation period that ends on the A3a date. (Divide the week's total fluid intake by 7 to validate the average of fluid intake per day.)**
Section M **CMS Update**	**Skin Condition**	To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last 7 days. Skin does not include eyes or oral mucosa.

M	**Skin Condition**	For the MDS assessment, staging of ulcers should be coded in terms of what is seen (i.e., visible tissue) during the look back period. For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a "2" for purposes of the MDS assessment. Facilities certainly may adopt the National Pressure Ulcer Advisory Panel (NPUAP) standards in their clinical practice. However, the NPUAP standards cannot be used for coding on the MDS.
	<u>Addendum Item</u>	A weekly skin assessment recorded on a log, along with other residents which does not become part of the individual resident's clinical record will not be considered as supporting documentation for validation purposes. A weekly skin assessment must be part of the individual resident's clinical record during the observation period that ends on the A3a date to be considered for validation purposes.
M1a-d	**Ulcers**	**Intent:** To record the number of skin ulcers, at each ulcer stage, on any part of the body. **Definition**: For coding in this section, a skin ulcer can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Skin ulcers that develop because of circulatory problems or pressure are coded in item M1. Rashes without open areas, burns, desensitized skin ulcers related to diseases such as syphilis and cancer and surgical wounds are NOT coded here, but are included in Item M4. Skin tears/shears are coded in Item M4 unless pressure was a contributing factor. **a. Stage 1.** A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. **b. Stage 2.** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, scab or shallow crater. **c. Stage 3.** A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue. **d. Stage 4.** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. **Process:** Review the resident's record and consult with the nurse assistant about the presence of any skin ulcers. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, a skin ulcer can be missed.

M1a-d **(7-day look back)**	**Ulcers** **<u>Addendum Item</u>** **Clarifications:** **p. 3-159 to 3-161**	Assessing a Stage 1 skin ulcer requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look; (3) a subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break. The Office of Inspector General is responsible for determining the effectiveness of an ulcer treatment. The review nurse(s) may observe an ulcer, at his/her discretion, if the ulcer was documented as present during the MDS observation period and remains under treatment at the time of the review. (The review nurse(s) shall take into consideration that the ulcer may have improved or deteriorated since the time of the MDS observation period.) ♦ All skin ulcers present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of problems or ulcers, as observed during the assessment period. ♦ Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The skin ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in Item M5 (Skin Treatments). *Do NOT code the debrided skin ulcer as a surgical wound. ♦ If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed. **Documentation pertaining to the number, size, description (e.g., appearance, size, depth, color, and so forth), care and the resident's response to treatment of pressure ulcer(s) shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M2 **M2a**	**Type of Ulcer** **Pressure Ulcer**	**Intent:** To record the highest stage for two types of *skin ulcers, Pressure and Stasis, that was present in the last 7 days. **Definition:** Any *skin ulcer caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers.

M2a	**Pressure Ulcer**	**Process:** Review the resident's record. Consult with the physician regarding the cause of the ulcer(s). More definitive information concerning pressure ulcers is provided in the AHRQ Guidelines for pressure ulcers in adults at: **http://www.ahrq.gov/consumer/bodysys/edbody6.htm.**
	Addendum Item	The Office of Inspector General is responsible for determining the effectiveness of a pressure ulcer treatment. The review nurse(s) may observe a pressure ulcer, at his/her discretion, if the pressure ulcer was documented as present during the MDS observation period and remains under treatment at the time of the review. (The review nurse(s) shall take into consideration that the pressure ulcer may have improved or deteriorated since the time of the MDS observation period.)
	What are Pressure Ulcers?	A pressure ulcer is an injury usually caused by unrelieved pressure that damages the skin and underlying tissue. Pressure ulcers are also called decubitus ulcers or bedsores and range in severity from mild (minor skin reddening) to severe (deep craters down to muscle and bone). Unrelieved pressure on the skin squeezes tiny blood vessels, which supply the skin with nutrients and oxygen. When skin is starved of nutrients and oxygen for too long, the tissue dies and a pressure ulcer forms. The affected area may feel warmer than surrounding tissue. Skin reddening that disappears after pressure is removed is normal and not a pressure ulcer. Other factors cause pressure ulcers, too. If a person slides down in the bed or chair, blood vessels can stretch or bend and cause pressure ulcers. Even slight rubbing or friction on the skin may cause minor pressure ulcers.
	Where Pressure Ulcers Form	Pressure ulcers form where bone causes the greatest force on the skin and tissue, and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. In persons who must stay in bed, most pressure ulcers form on the lower back below the waist (sacrum), the hip bone (trochanter), and on the heels. In people in chairs or wheelchairs, the exact spot where pressure ulcers form depends on the sitting position. Pressure ulcers can also form on the knees, ankles, shoulder blades, back of the head, and spine. Nerves normally tell the body when to move to relieve pressure on the skin. Persons in bed who are unable to move may get pressure ulcers after as little as 1-2 hours. Persons who sit in chairs and who cannot move can get pressure ulcers in even less time because the force on the skin is greater.

M2a **(7-day look back)**	**Where Pressure Ulcers Form** **Pressure Ulcers Clarifications:** **p. 3-161 to 3-164**	NOTE: It is also common for pressure ulcers to form on the ears and scrotum. The full AHCRP guideline for clinicians can be found at: **http://www.ahcpr.gov/clinic/cpgonline.htm.** ♦ In order to code Pressure Ulcers in the case of a blister, the key is to determine if there was a source of pressure that caused the blister. In the presence of moisture, less pressure may be required to develop a pressure ulcer. If, for example, a blister was found in the area of the incontinence brief waist or leg band, pressure from the band may be a likely cause of the blister and the assessor would record the blister as a pressure ulcer. If no source of pressure could be identified, the blister may be evidence of perineal dermatitis caused by excessive urine or stool eroding the epidermis. No pressure is required for perineal dermatitis to occur. If this is the case, the blister would not be recorded as a pressure ulcer, but would be considered a rash. For additional information, refer to Lyder, C. (1997). Perineal dermatitis in the elderly: A critical review of the literature. Journal of Gerontological Nursing 23(12), 5-10. ♦ If there is persistent redness without a break in the skin that does not disappear when pressure is relieved, the problem should be recorded as a Stage 1 ulcer (M1). Less pressure is needed for a pressure ulcer to form when the skin is soiled with urine and/or feces. If the resident is unable to move, or does not move to relieve pressure on the skin, then pressure is very likely to have helped form the ulcer. Item M1a should be coded as "1" and M2a should be coded for the highest stage. In addition, if this is a situation where there is redness from pressure in combination with a contact rash from incontinence, especially if the resident was wet long enough to develop the rash, code Item M2a (pressure ulcer for the highest stage). If the resident's mobility status is not impaired (i.e., they can move to relieve pressure on the skin) and the redness is not likely due to pressure, do not code Item M2a. Code the condition in M4, Other Skin Problems or Lesions Present. *(See examples for coding on p. 3-164.) **Documentation pertaining to the highest stage for Pressure ulcer(s) seen during the 7-day observation period that ends on the A3a date shall be present in the clinical record.**
M4	**Other Skin Problems or Lesions Present** **CMS Update**	**Intent:** To document the presence of skin problems or lesions (other than pressure or circulatory skin ulcers) and conditions that are risk factors for more serious problems. Skin does not include eyes or oral mucosa.

M4	**Addendum Item**	CMS has indicated that "Skin tears/shears are coded in Item M4 unless pressure was a contributing factor.
M4b	**Burns (Second or Third Degree)**	**Definition:** Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first degree burns (changes in skin color only). **Process:** Ask the resident if he or she has any problem areas. Examine the resident. Ask the nurse assistant. Review the resident's record.
(7-day look back)	**p. 3-165**	**Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M4c	**Open Lesions/ Sores (e.g., Cancer Lesions)**	Code in M4c any skin lesions that are not coded elsewhere in Section M. Include skin ulcers that developed as a result of diseases and conditions such as syphilis and cancer. Do NOT code skin tears or cuts here. **Process:** Ask the resident if he or she has any problem areas. Examine the resident. Ask the nurse assistant. Review the resident's record.
	Addendum Item	"A cyst, not otherwise described, would not be coded as an open lesion. Documentation of a cyst does NOT meet the first criteria of 'open' in Section M4c."
7-day look back)	**p. 3-165**	**Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M4g	**Surgical Wounds** **CMS Update**	**Definition:** Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include surgical wounds of the eyes or oral mucosa, healed surgical sites, stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds. **Process:** Ask the resident if he or she has any problem areas. Examine the resident. Ask the nurse assistant. Review the resident's record.
	Addendum Item	CMS – A surgical wound that has healed but reopened, and remained open, during the 7-day observation period could be coded again as a surgical wound at M4g. (Refer to p. 3-166…."includes healing and non-healing, open or closed….")
(7-day look back)	**p. 3-166**	**Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**

M5	**Skin Treatments**	**Intent:** To document any specific or generic skin treatments the resident has received in the past 7 days.
	Clarifications:	♦ Good clinical practice dictates that staff should document treatments provided (e.g., the items listed in M5 and M6). Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility. ♦ Dressings do not have to be applied daily in order to be coded on the MDS. If any dressing meeting the MDS definitions provided for MDS Items M5e-h was applied even once during the 7-day period, the assessor would check the appropriate MDS item.
	p. 3-167 to 3-168	
M5a	**Pressure Relieving Device(s) for Chair**	**Definition:** Includes gel, air (e.g., Roho) or other cushioning placed on a chair or wheelchair. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate cushions in this category. **Process:** Review the resident's records. Ask the resident and nurse assistant.
	<u>Addendum Items</u>	Documentation for a pressure relieving device to chair must include the type of device (i.e., gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Do NOT include egg crate cushions in this category (p. 3-167). A bed pillow in a wheelchair does NOT meet the criteria for a pressure-relieving device for a chair. "A facility may document the type of pressure relieving device (air, fluid, etc.) or the brand name for chair/bed. IF the facility only documents the brand name, the field review nurse would request to review the manufacturer's literature on the device to verify that it meets the criteria defined on p. 3-167," per Task Force.
(7-day look back)	**p. 3-167**	**Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M5b	**Pressure Relieving Device(s) for Bed**	**Definition:** Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate mattresses in this category. **Process:** Review the resident's records. Ask the resident and nurse assistant.

M5b **(7-day look back)**	**<u>Addendum Items</u>** **p. 3-167**	Documentation for a pressure relieving device to bed must include the type of device (i.e., air fluidized, low airloss therapy beds, flotation, water, or bubble mattress or pad placed on the bed.) Do NOT include egg crate cushions in this category. A foot cradle would not be coded under M5b because, clinically speaking, the mattress devices described on p. 3-167 are used to relieve the pressure of the body from the mattress. A foot cradle is used to relieve the weight of the bed linens from the feet and lower legs. They are different devices used for different reasons, per CMS. **Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M5c **(7-day look back)**	**Turning/ Repositioning Program** **p. 3-167**	**Definition:** Includes a continuous, consistent program for changing the resident's position and realigning the body. "Program" is defined as "a specific approach that is organized, planned, documented, monitored, and evaluated." **Process:** Review the resident's records. Ask the resident and nurse assistant. **Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M5d **(7-day look back)**	**Nutrition or Hydration Intervention to Manage Skin Problems** **p. 3-167**	**Definition:** Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions (e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing. Vitamins and minerals, such as Vitamin C and Zinc, which are used to manage a potential or active skin problem, should be coded here. **Process:** Review the resident's records. Ask the resident and nurse assistant. **Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M5e	**Ulcer Care** **<u>CMS Update</u>**	**Definition:** Includes any intervention for treating skin problems coded in M1, M2 and<u>/or</u> M4c. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy. **Process:** Review the resident's records. Ask the resident and nurse assistant.

M5e **(7-day look back)**	**Ulcer Care** **p. 3-167**	**Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M5f **(7-day look back)**	**Surgical Wound Care** **p. 3-167**	**Definition:** Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture removal, and warm soaks or heat application. **Process:** Review the resident's records. Ask the resident and nurse assistant. **Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M5g **(7-day look back)**	**Application of Dressings (With or Without Topical Medications) Other Than to Feet** **<u>Addendum Items</u>** **p. 3-167 & 3-168**	**Definition:** Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles. **Process:** Review the resident's records. Ask the resident and nurse assistant. The application of a Band-Aid does meet CMS' definition of a dressing IF applied for ulcer care or wound care. (p. 3-167.) CMS – "A 'dressing' could be coded here for the eye, if you were using a patch for some non-surgical intervention to the eye." A Tegaderm dressing on a skin tear that was applied prior to the 7-day observation period and nurses were only checking to see that it was still intact would NOT meet the definition of application as outlined on p. 3-167 & 3-168. If the dressing was not "applied" during the 7-day observation period, do NOT code it. Curagel dressings are pre-treated and should be coded under M5g. **Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M5h	**Application of Ointments/ Medications (Other Than to Feet)**	**Definition:** Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

M5h **(7-day look back)**	**<u>Addendum Items</u>** **p. 3-168**	**Process:** Review the resident's records. Ask the resident and nurse assistant. CMS – "Eye drops do NOT meet the criteria for application of ointments/medications." The definition on p. 3-168 states "include ointments or medications used to treat a skin condition." In addition, normal saline can NOT be counted as an ointment/medication in Section M5h." "Crisco should NOT be coded under M5h. Crisco is neither an ointment nor a medication" per Task Force. Curagel dressings should NOT be coded under M5h. **Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M6 **(7-day look back)**	**Foot Problems and Care** **Clarification: p. 3-168 & 3-169** **Infection of the Foot** **p. 3-168**	**Intent:** To document the presence of foot problems and care to the feet during the last 7 days. ♦ For MDS coding, ankle problems are NOT considered foot problems and should NOT be coded in Item M6. Code in Item M5. **Definition:** e.g., Cellulitis, Purulent Drainage **Process:** Ask the resident and nurse assistant. Inspect the resident's feet. Review the resident's clinical records. **Documentation of a physician's diagnosis of an infection of the foot and treatment shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M6c **(7-day look back)**	**Open Lesions On the Foot** **p. 3-168**	**Definition:** Includes cuts, ulcers, fissures. **Process:** Ask the resident and nurse assistant. Inspect the resident's feet. Review the resident's clinical records. **Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
M6f	**Application of Dressings (With or Without Topical Medications)**	**Definition:** Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

M6f **(7-day look back)**	 **p. 3-169**	**Process:** Ask the resident and nurse assistant. Inspect the resident's feet. Review the resident's clinical records. **Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
Section N	**Activity Pursuit Patterns**	**Intent:** To record the amount and types of interests and activities that the resident currently pursues, as well as activities the resident would like to pursue that are not currently available at the facility.
	Activity Pursuits **p. 3-169**	**Definition:** Refers to any activity other than ADLs that a resident pursues in order to enhance a sense of well being. These include activities that provide increased self-esteem, pleasure, comfort, education, creativity, success, and financial or emotional independence.
N1	**Time Awake**	**Intent:** To identify those periods of a typical day (over the last 7 days) when the resident was awake all or most of the time (i.e., no more than one hour nap during any such period). For care planning purposes, this information can be used in at least two ways: ▪ The resident who is awake most of the time could be encouraged to become more mentally, physically, and/or socially involved in activities (solitary or group). ▪ The resident who naps a lot may be bored or depressed and could possibly benefit from greater activity involvement.
N1a	**Morning**	**Definition:** Morning is from 7 a.m. (or when resident wakes up, if earlier or later than 7 a.m.) until noon.
N1b	**Afternoon**	**Definition:** Afternoon is from noon to 5 p.m.
N1c	**Evening**	**Definition:** Evening is from 5 p.m. to 10 p.m. (or bedtime, if earlier.
N1a, b, c	**Time Awake**	**Process:** Consult with direct care staff, the resident, and the resident's family.

N1a, b, c	**Time Awake Clarifications:**	▪ When coding this item, check each time period, as defined for that resident, during which he or she did not nap for more than one hour. Some examples of coding are as follows: 1. A resident wakes up every morning at 7 a.m. He/she typically eats breakfast, has a shower, gets dressed and goes back to bed for a late morning nap from 10 a.m. until 11:30 a.m. Item N1a (Morning) should NOT be checked, since this resident typically naps for more than 1 hour during the morning. 2. A resident typically wakes up at 6 a.m. She/He is busy with therapy and activities most of the day, and does not take naps. She/He goes to bed by 7 p.m. every evening. Items N1a (Morning), N1b (Afternoon) and N1c (Evening) should all be checked, since this resident does not take naps. 3. A resident who is bedfast and has end-stage Alzheimer's disease wakes up at 6 a.m. daily. She/He typically dozes off throughout the day, napping for more than 1 hour before noon, and again from 3:30 p.m. to 5:30 p.m. every afternoon. She/He is typically awake from 5:30 p.m. until 9 p.m. After that, she's/he's asleep for the night. Items N1a (Morning) and N1b (Afternoon) should NOT be checked, since this resident naps for more than one hour during each of these periods. Item N1c (Evening) should be checked as time awake. Although this resident sleeps until 5:30 p.m., that is only a 30-minute naptime in the evening period. ▪ Accurate coding relies on the use of appropriate information-gathering techniques. Coding Items N1a, b, and c based on only the assessor's personal knowledge of a resident's typical day may result in an inaccurate response to this item. Documentation review is important. However, we would generally not expect facility staff to maintain flowcharts for information such as sleep and awake times. ▪ It is important to observe the resident across all shifts. In addition, the same individual staff member is generally not on duty and available to observe a resident across a 24-hour period. It's important to supplement observation with interviews of the resident, their family members, other staff across shifts, and in particular, the nursing assistants caring for the resident.

N1a, b, c **(7-day look back)**	**Time Awake** **p. 3-169 to 3-171**	**Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
Section O3	**Injections**	**Intent:** To determine the number of DAYS during the past 7 days that the resident received any type of medication, antigen, vaccine, by subcutaneous, intramuscular or intradermal injection. Although antigens and vaccines are considered "biologicals" and not medication per se, it is important to track when they are given to monitor for localized or systemic reactions. This category does NOT include intravenous (IV) fluids or medications. If the resident received IV fluids, record in Item K5a, Parenteral/IV. If IV medications were given, record in Item P1ac, IV medications.
	Clarifications:	▪ Administration of Epogen should be recorded in several places in Section O, depending on its route of administration and date of initiation. It should be counted at MDS Item O1 (Number of Medications), and if it was initiated during the last 90 days, it should also be indicated at MDS Item O2 (New Medication). If the Epogen was given subcutaneously, also record it in Item O3 (Injections). If it is given intravenously, it should be indicated at MDS Item P1ac (IV medication). ▪ If the resident received an injection of Vitamin B12 prior to the observation period, code in Item O1. Vitamin B12 maintains a blood level, as do long acting antipsychotics**.** Determine if a specific long-acting medication is still active based on physician, pharmacist, and/or PDR input. Do NOT code Vitamin B12 injections in Item O3 (Injections) if it was given outside of the observation period. ▪ Subcutaneous pumps would be coded as follows: O1 – Count the medication as a medication; O2 – Identify if this was a new medication or not; O3 – Code <u>only</u> the number of days that the resident actually required a subcutaneous injection to restart the pump. • If a test or vaccination is provided on one day and another vaccine provided on the next day, code "2" for the number of days when the resident received injections. If both injections were administered on the same day, code "1".

O3	**Injections Clarifications:**	Examples: During the last 7 days, Mr. T received a flu shot on Monday, a PPD test (for tuberculosis) on Tuesday, a Vitamin B12 injection on Wednesday. Code "3" for Resident received injections on three days during the last 7 days. During the last 7 days, Miss C received a flu shot and her Vitamin B12 injection on Thursday. Code "1" for resident received 2 injections on the same day in the last 7 days.
(7-day look back)	**q. 3-177 to 3-179**	**Documentation shall be present in the clinical record during the 7-day observation period that ends on the A3a date.**
Section P	**Special Treatments, Procedures and Programs**	**Intent:** To identify any special treatments, therapies, or programs that the resident received in the specified time period. Do NOT code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post procedure recovery period.
P1a	**Special Care**	**Treatments –** The following treatments may be received by a nursing facility resident either at the facility, at a hospital as an outpatient, or as an inpatient, etc. **Definitions:**
P1aa	**Chemotherapy**	**a.** Includes any type of chemotherapy (anticancer drug) given by any route. The drugs coded here are those actually used for cancer treatment. For example, Megace (megestrol ascetate) is classified in the Physician's Desk Reference (PDR) as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If Megace is being given only for appetite stimulation, do NOT code it as chemotherapy in this item. The resident is not receiving chemotherapy in these situations. Each drug should be evaluated to determine its reason for use before coding it here. IVs, IV medications, and blood transfusions provided during chemotherapy are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).
	<u>Addendum Item</u>	CMS – "When a resident with a cancer diagnosis is given a long-acting chemotherapy treatment once every 3 months, it should NOT be coded unless it was given within the 14-day observation period that ends on the A3a date."

P1ab	**Dialysis**	**b.** Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH) and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medications, and blood transfusions administered during dialysis are NOT coded under the respective Items K5a (Parenteral/IV), P1ac (IV Medications) and P1ak (Transfusions).
	Addendum Item	A physician's progress note or nursing care plan dated during the 14-day observation period that states, "Resident out to dialysis ___ times a week" would be supporting documentation to transmit P1ab (Dialysis). If NOT found, the review nurse shall look for nurses notes or a statement from the Dialysis Center during the 14-day observation period per Task Force.
P1ac	**IV Medication**	**c.** Includes any drug given by intravenous push or drip through a central or peripheral port. Does NOT include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Record the use of an epidural pump in this item. Epidurals, intrathecal, and Baclofen pumps may be coded, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance.
P1ag	**Oxygen Therapy**	**g.** Includes continuous or intermittent oxygen via mask, cannula, etc. (Does NOT include hyperbaric oxygen for wound therapy).
P1ah	**Radiation**	**h.** Includes radiation therapy or having a radiation implant.
P1ai	**Suctioning**	**i.** Includes nasopharyngeal or tracheal aspiration ONLY. Oral suctioning should NOT be coded here.
P1aj	**Tracheostomy Care**	**j.** Includes cleansing of tracheostomy AND cannula.
	Addendum Items	CMS – "Tracheostomy care includes cleansing of tracheostomy AND cannula. When a resident has a trach with a disposable cannula and there is no cleaning required (only replacement), it is possible, under this instance to NOT code the tracheostomy unless the cannula has been changed in the 14-day observation period." If the resident has a stoma ONLY and the facility transmitted "tracheostomy care", it would NOT be a valid response. However, if the resident has an inner OR outer cannula (disposable or non-disposable), the documentation shall indicate more than merely "changing the cannula" to be a valid response for trach care, if all other criteria were met per Task Force.

P1ak	**Transfusions**	**k.** Includes transfusions of blood or any blood products (e.g., platelets), which are administered directly into the bloodstream. Do NOT include transfusions that were administered during dialysis or chemotherapy.
P1al	**Ventilator or Respirator**	**l.** Assures adequate ventilation in residents who are, or who may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices. Any resident who was in the process of being weaned off of the ventilator or respirator in the last 14 days should be coded under this definition. Does NOT include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.
	Clarifications:	• Residents with sleep apnea may undergo treatments with a mask-like device that is being used to keep the airway open during sleep. This service cannot be coded as a ventilator or a respirator. According to the American Academy of Otolaryngology-Head and Neck Surgery, Inc., a CPAP (Continuous Positive Airway Pressure) device delivers air into your airway through a specially designed mask or pillows. The mask does not breathe for you; the flow of air creates enough pressure when you inhale to keep your airway open. Ventilators are sometimes used to deliver this type of non-invasive ventilation when CPAP or BIPAP machines are not available. In these cases, the ventilator is merely providing air, not traditional life support via invasive measures and does not require the same level of intensity of care that life support ventilation demands. • Do NOT code services that were provided solely in conjunction with a surgical procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.
(14-day look back)	**p. 3-182 to 3-184**	**Documentation shall be present in the clinical record during the 14-day observation period that ends on the A3a date.**
P1b	**Therapies**	Therapies that occurred after admission/readmission to the nursing facility, were ordered by a physician, and were performed by a qualified therapist (i.e., one who meets State credentialing requirements or in some instances, under such a person's direct supervision). The licensed therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy

P1b	**Therapies**	services provided to residents. Includes ONLY medically necessary therapies furnished AFTER admission to the nursing facility. Also includes ONLY therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. The therapy treatment may occur either inside or outside the facility.
	Addendum Item	CMS – "The beneficiary's needs and goals during an acute care hospital stay are not necessarily the same as those that will be established during the SNF stay. Although the physician and therapist should review the hospital evaluation, if available, the therapist MUST perform a full evaluation of the beneficiary as he/she presents in the facility. The plan of treatment is then developed by the physician and the therapist to address the beneficiary's needs and goals during the post-acute stay at the SNF."
		Intent: To record the (A) number of days and (B) total number of minutes each of the following therapies was administered to residents (for at least 15 minutes a day) in the last 7 days.
		Definition:
P1ba		**a. Speech – Language Pathology, Audiology Services –** Services that are provided by a licensed speech-language pathologist.
P1bb		**b. Occupational Therapy –** Therapy services that are provided or directly supervised by a licensed occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing facility ONLY if he or she is under the direction of a licensed occupational therapist.
P1bc		**c. Physical Therapy –** Therapy services that are provided or directly supervised by a licensed physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility ONLY if he or she is under the direction of a licensed physical therapist.
	Addendum Item	DMS – CMS has not approved Anodyne (Infrared) treatments. They are still considered "investigational/experimental" at this time. The field review nurse shall not give credit for these treatments if documented on the MDS. All such treatments will be referred to DMS until further clarification is received from CMS.

P1bd		**d. Respiratory Therapy –** Therapy services that are provided by a by a qualified professional (respiratory therapists, trained nurse). Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist). Does not include hand-held medication dispensers. Count only the time that the qualified professional spends with the resident. (See clarification below defining "trained nurse.") A trained nurse may perform the assessment and the treatments when permitted by the state nurse practice act. **Process:** Review the resident's clinical record and consult with each of the qualified therapist. A therapist's initial evaluation time may NOT be counted, but subsequent evaluations, conducted as part of the treatment process, may be counted.
	Addendum Items	A record of the number of days and total number of minutes of Respiratory Therapy is necessary to support coding the MDS. The Review Nurse(s) will look at the therapy documentation that occurred during the 7-day observation period that ends on the A3a date, verify the physician's order, the therapist's (qualified professional, i.e., trained nurse, respiratory therapist) assessment and treatment plan that is documented in the resident's clinical record. *The review nurse must see actual therapy minutes in order to give credit for respiratory therapy services per Task Force. "There is not a specific requirement in the RAI manual as to what the assessment should include. The field review nurse will accept an assessment provided by a "trained nurse" (i.e., "Trained Nurse" refers to a nurse who received specific training on the administration of respiratory treatments and procedures".) The trained nurse ("qualified professional") can be any licensed nurse (i.e., RN or LPN). The fact that the nurse is licensed is NOT sufficient. The review nurse must see documentation that either the "trained" nurse OR "trained" nurse in-service coordinator has received their training by a respiratory therapist per Task Force. The documentation that would be acceptable for a nurse who obtained respiratory therapy training as part of her nurses training would be any type of documentation (i.e., orientation check list, in-service on respiratory therapy, continuing education attendance, on-the-job-training, etc.) presented by the Provider. The MDS User's Manual does not address who is qualified to train nurses in respiratory therapy techniques.

P1b	**Therapy** **Clarifications:**	Coding Minutes of Therapy: • Includes only therapies that were provided once the individual is actually living/being cared for at the facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other nursing facility, or a recipient of home care or community-based services. If a resident returns from a hospital stay and a readmission assessment is done, count ONLY those therapies that occurred since readmission to the facility. • If a whirlpool treatment is specifically ordered by a physician to be performed by or under the supervision of a physical therapist, it may be coded as therapy. • Transdermal Wound Stimulation (TEWS) treatment for wounds can be coded in Item P1b when complex wound care procedures, requiring the specialized skills of a licensed therapist, are ordered by a physician. However, routine wound care, such as applying/changing dressings, should NOT be coded as therapy, even when performed by therapists. • Qualified professionals for the delivery of respiratory services include "trained nurses". A trained nurse refers to a nurse who received specific training on the administration of respiratory treatments and procedures. This training may have been provided at the facility during a previous work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training programs. • The MDS instructions clearly require reporting the actual minutes of therapy received by the resident. • The resident's treatment time starts when he/she begins the first treatment activity or task and ends when he/she finishes with the last apparatus and the treatment is ended. • The time required to adjust equipment or otherwise prepare for the individualized therapy of a particular resident, is the set-up time and may be included in the count of minutes of therapy delivered to the resident. • The therapist's time spent on documentation or on initial evaluation may NOT be included. • Time spent on periodic reevaluations conducted during the course of a therapy treatment may be included.

P1b	**Therapy Clarifications:**	• Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as a family-funded service) may NOT be counted in P1b, even when performed by a licensed therapist. • Historically, units of therapy time have been used for billing and have been derived from the actual therapy minutes. For MDS reporting purposes, conversion from units to minutes is not appropriate and the actual minutes are the only appropriate measures that can be counted for completion of Item P1b. Please note that therapy logs are not an MDS requirement, but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment. • Facilities may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services may NOT be coded as therapy in Item P1b, since the specific interventions would be considered restorative nursing services when performed by nurses or aides. • <u>For Medicare A only:</u> A licensed therapist starts work directly with one resident beginning a specific task. Once the resident can proceed with supervision, the licensed therapist works directly with a second resident to get him/her started on a different task, while continuing to supervise the first resident. The treatment ends for each resident 30 minutes after it begins. For each session, record 30 minutes therapy time for each resident at Item P1bB. This delivery of therapy is often referred to as supervisory treatment, dovetailing, or concurrent therapy. <u>Medicare B only recognizes individual (one-on-one) therapy and group therapy.</u> • In some cases, the resident will be able to perform part of the treatment tasks with supervision, once set up appropriately. Time supervising the resident is a part of total treatment time. For example, as the last treatment task of the day, a resident uses an exercise bicycle for 10 minutes. It may take the therapist 2 minutes to set the resident up on the apparatus. The therapist or assistant, under the supervision of a PT, may then leave the resident to help another resident in the same exercise room. However, the therapist still has eye contact with the resident and is providing supervision, verbal encouragement and direction to the resident on the bicycle. Therefore, if it took 2 minutes to set the resident up with the cycling apparatus, the resident was

P1b	**Therapy Clarifications:**	supervised during two 5-minute cycling periods; one 2-minute rest between the exercise periods; and took 1 minute to get out of the apparatus, the total cycling activity is 15 minutes. Include in this example that the resident did three additional treatment activities totaling 45 minutes before beginning to cycle. The total time reported on the MDS assessment is 60 minutes. The key is that the resident was receiving treatment the entire time and had the physical presence of a therapist in the room, supervising the entire treatment process. • Two licensed therapists, each from a different discipline, begin treating one resident at the same time. The treatment ends 30 minutes after it starts. For each session, record 30 minutes total therapy time for the resident at Item P1bB. Split the time between the two disciplines as appropriate. For example, PT = 20 minutes, OT = 10 minutes; or PT = 15 minutes, OT = 15 minutes, etc. In the first example, where the beneficiary received 20 minutes of PT and only 10 minutes of OT, for each session code 1 day of PT at Item P1bA, and 20 minutes of PT at Item P1bB. Also code the 10 minutes of OT in Item P1bB. In this example, no days may be coded for OT at Item P1bA, because the sessions only lasted 10 minutes. Group Therapy (for Speech-Language Pathology and Occupational and Physical Therapies): • For groups of four or fewer residents per supervising therapist (or assistant), each resident is coded as having received the full time in the therapy session. For example, if a therapist worked with three residents for 45 minutes on training to return to the community, each resident received 45 minutes of therapy so long as that does not exceed 25% of his/her therapy time per therapy discipline, during the 7-day observation period. Remember, code for the resident's time, not for the therapist's time. Note: The 25% rule only applies to Medicare A residents. Supervision (Medicare A only): • Aides cannot independently provide a skilled service. The services of aides performing therapy treatments may only be coded when the services are performed under line of sight supervision by a licensed therapist when allowed by state law. This type of coordination between the licensed therapist and therapy aide under the direct, personal (e.g., line of sight) supervision of the therapist is considered individual therapy for counting minutes. When the therapist starts the session and delegates the performance of the therapy treatment to a therapy aide,

P1b **(7-day look back)**	**Therapy Clarifications:** **p. 3-185 to p. 3-190**	while maintaining direct line of sight supervision, the total number of minutes of the therapy session may be coded as therapy minutes. • Therapy students are recognized as skilled providers under Medicare A only. They must be "in line of sight" supervision (Federal Register November 4, 1999). Maintenance Therapy/Nursing Rehabilitation: • Once the licensed therapist has designed a maintenance program and discharged the resident from the rehabilitation (i.e., skilled) therapy programs, the services performed by the therapist and the aide should no longer be reported at Item P1b as skilled therapy. The services of the aide may be reported on the MD assessment as restorative nursing at Item P3, provided they meet the requirements for restorative therapy. • There may be situations where nursing staff request assistance from a licensed therapist to evaluate the restorative nursing aides or to recommend changes to a restorative nursing program. Consultation with nursing staff and staff training are certainly good clinical practice. The therapist's time cannot be reported as skilled therapy in P3. Example: Following a stroke, Mrs. F was admitted to the nursing facility in stable condition for rehabilitation therapies. Since admission, she has been receiving speech therapy twice weekly for 30-minute sessions, occupational therapy twice weekly for 30-minute sessions and physical therapy twice a day (30-minute sessions) for 5 days and respiratory therapy for 10 minutes per day on each of the last 7 days. During the last 7 days, Mrs. F has participated in all of her scheduled sessions. Coding — A — B a) Speech-language pathology, Audiology services — 2 — 60 b) Occupational therapy — 2 — 60 c) Physical therapy — 5 — 300 d) Respiratory therapy — 0 — 70 e) Psychological therapy — 0 — 0 **Documentation shall be present in the clinical record for each of the above mentioned therapies during the 7-day observation period that ends with the A3a date.**

P3	**Nursing Rehabilitation/ Restorative Care**	**Intent:** To determine the extent to which the resident receives nursing rehabilitation or restorative services from other than specialized therapy staff (e.g., occupational therapist, physical therapist, etc.). Rehabilitative or restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. A resident may also be started on a restorative program when he/she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when a restorative need arises during the course of a custodial stay. Restorative nursing does NOT require a physician's order. Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment. **Definition:** Included are nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in item P1b. In addition, to be included in this section, a rehabilitation or restorative care must meet ALL of the following additional criteria: • Measurable objectives and interventions must be documented in the care plan and in the clinical record. • Evidence of periodic evaluation by licensed nurse must be present in the clinical record. • Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity. • These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. • This category does not include groups with more than four residents per supervising helper or caregiver.
	<u>Addendum Items</u>	There must be a plan of care specific to the resident's restorative nursing care with measurable objectives and interventions. This plan may either be an interdisciplinary care plan or a separate restorative care plan. The care plan must meet the nursing rehabilitation/restorative care MDS User's Manual Guidelines. A check form or flow sheet that demonstrates the completion of the

P3	**Nursing Rehabilitation/ Restorative Care <u>Addendum Items</u>**	restorative treatment as specified in the care plan IS acceptable. It is NOT required that actual minutes be recorded as the restorative measures are performed, as long as the plan of care details the minutes and frequency of the restorative measures. Task Force – The field review nurse is not required to look for nursing rehabilitation/restorative training IF the services are performed by licensed staff. The field review nurse must look for training IF a State Registered Nursing Assistant (SRNA) provides the services. It would <u>NOT</u> be appropriate for licensed staff to sign for this service IF the SRNA actually performed the services. The Nursing Rehabilitation/Restorative Care may be provided by the nurse assistants/aides or other staff and volunteers during the 7-day observation period that ends on the A3a date. The Review Nurse(s) will be required to: • Validate measurable objectives and interventions were documented in the care plan and in the clinical record. The use of "and" does not mean that objectives and interventions have to be in both places IF the documentation is considered a permanent part of the clinical record. When reviewing for restorative nursing care and the care plan states the number of minutes to be provided but, the actual flow sheet provided indicates a different number of minutes, the flow sheet shall "override" the care plan per Task Force. • The nurse aide care plan is acceptable for coverage of minutes to validate nursing rehabilitation & restorative. A grid form is not necessary if the nurse aide staff sign the back of the nurse aide care plan daily. • Validate evidence of "periodic evaluation" by licensed nurse was present in the clinical record. A "periodic evaluation" shall be defined in the NF's Policy and Procedure Manual. The MDS User's Manual does not define "periodic evaluation by licensed nurse". A signature by a licensed nurse is sufficient for evidence of documentation for validation purposes, per Task Force. • Validate documentation that the nurse assistants/aides were trained in the techniques that promote resident involvement in the activity. <u>For validation purposes</u>, if a nurse aide has NOT completed training classes, then additional documentation that reflects restorative care would be required (i.e., orientation checklist, inservice on restorative techniques, etc.). The review nurse shall ask to see the SRNA certification/training for aides providing restorative nursing care. This shall be done EVERY TIME the review is performed regardless of how well the review nurse may know the facility and staff members per Task Force.

P3	**Nursing Rehabilitation/ Restorative Care** **Addendum Items**	• Validate documentation that the activities were carried out or supervised by members of the nursing staff. If other staff and volunteers were assigned to work with specific residents, validate documentation that they were under a licensed nurse's supervision. • Validate documentation that no more than four (4) residents were included in exercise groups per supervising helper or caregiver. (Refer to p. 3-192)
		Definitions:
P3a		**a. Range of Motion (Passive) –** The extent to which, or the limits between which, a part of the body can be moved around a fixed point or joint. A program of passive movements to maintain flexibility and useful motion in the joints of the body. The caregiver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance. These exercises must be planned, scheduled and documented in the clinical record. Helping a resident get dressed does NOT, in and of itself, constitute a range of motion exercise session.
	Addendum Item	Range of Motion (Passive) was not changed by CMS; therefore, Assisted PROM (APROM) will NOT be accepted by the review nurse as supporting documentation for validation purposes.
P3b		**b. Range of Motion (Active) –** Exercises performed by a resident, with cueing, supervision *or physical assist by staff, that are planned, scheduled, and documented in the clinical record. *Include active ROM and active assisted ROM. Any participation by the resident in the ROM activity should be coded here.
	Addendum Item	CMS – (Clarify coding on p. 3-192) Range of Motion (Active) – "Exercises performed by a resident, with cueing, supervision or physical assist by staff, that are planned, scheduled, and documented in the clinical records. Include active ROM and "active assisted" ROM. Any participation by the resident in the ROM activity should be coded here."
P3c		**c. Splint or Brace Assistance –** Assistance can be of 2 types: 1) where staff provide verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint, or 2) where staff have a scheduled program of applying and removing a splint or brace, assess the resident's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

P3c		TRAINING AND SKILL PRACTICE IN: Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.
P3d		**d. Bed Mobility** – Activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.
P3e		**e. Transfer –** Activities used to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.
P3f		**f. Walking –** Activities used to improve or maintain the resident's self-performance in walking, with or without assistive devices.
P3g		**g. Dressing or Grooming –** Activities used to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.
P3h		**h. Eating or Swallowing –** Activities used to improve or maintain the resident's self-performance in feeding one's self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.
P3i		**i. Amputation/Prosthesis Care** – Activities used to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). "Dentures are not considered to be prostheses for coding this item.
P3j		**j. Communication –** Activities used to improve or maintain the resident's self-performance in using newly acquired functional communication skills or assisting the resident in using residual communication skills and adaptive devices.
P3	**Nursing Rehabilitation/ Restorative Care**	**Process:** Review the clinical record and the current care plan. Consult with facility staff. Look for rehabilitation/restorative care schedule, and implementation record sheet on the nursing unit.
	Clarifications:	♦ If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this "reassessment" should be documented in the record.

P3	**Nursing Rehabilitation/ Restorative Care Clarifications:**	♦ When not contraindicated by State practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established. ♦ Facilities may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services MAY NOT be coded as therapy in Item P1b, since the specific interventions are considered restorative nursing services when performed by nurses or aides. The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs. ♦ Active or passive movement by a resident that is incidental to dressing, bathing, etc. does NOT count as part of a formal restorative care program. For inclusion in this section, active or passive range of motion must be a component of an individualized program with measurable objectives and periodic evaluation delivered by staff specifically trained in the procedures. ♦ The use of Continuous Passive Motion (CPM) devices as Rehabilitation/Restorative Nursing is coded when the following criteria are met: 1) ordered by a physician, 2) nursing staff have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion), and 3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do NOT include the time the resident is receiving treatment in the device. Include only the actual time staff is required to apply the device and monitor. ♦ Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These grooming programs would need to have goals, objectives and documentation of progress included in the clinical record. Examples of Nursing Rehabilitation/Restoration: 1. Mr. V has lost range of motion (ROM) in his right arm, wrist and hand due to a CVA experienced several years ago. He has moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to his right arm, the occupational therapist fabricated a right resting hand splint and instructions for its application and removal. The nursing coordinator developed

P3	**Nursing Rehabilitation/ Restorative Care Clarifications:**	instructions for providing passive range of motion exercises to his right arm, wrist and hand 3 times per day. The nursing assistants and Mr. V's wife have been instructed on how and when to apply and remove the hand splint and how to do the passive ROM exercises. These plans are documented on Mr. V's care plan. The total amount of time involved each day in removing and applying the hand splint and completing the ROM exercises is 30 minutes. The nursing assistants report that there is less resistance in Mr. V's affected extremity when bathing and dressing him. For both Splint or Brace Assistance and Range of Motion (Passive), *enter "7" as the number of days these nursing rehabilitative techniques were provided.* 2. Mrs. K was admitted to the nursing facility 7 days ago following repair to a fractured hip. Physical therapy was delayed due to complications and a weakened condition. Upon admission, she had difficulty moving herself in bed and required total assistance for transfers. To prevent further deterioration and increase her independence, the nursing staff implemented a plan on the second day following admission to teach her how to move herself in bed and transfer from bed to chair using a trapeze, the bedrails, and a transfer board. The plan was documented in Mrs. K's clinical record and communicated to all staff at the change of shift. The charge nurse documented in the nurses notes that in the five days Mrs. K has been receiving training and skill practice for bed mobility and transferring, her endurance and strength are improving, and she requires only extensive assistance for transferring. Each day the amount of time to provide this nursing rehabilitation intervention has been decreasing so that for the past five days, the average time is 45 minutes. *Enter "5" as the number of days training and skill practice for bed mobility and transfer was provided.* 3. Mrs. J had a CVA less than a year ago resulting in left-sided hemiplegia. Mrs. J has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity of daily living. Mrs. J's overall care plan goal is to maximize her independence in ADLs. A plan, documented on the care plan, has been developed to teach Mrs. J how to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with velcro. The nursing assistants have been instructed in how to verbally guide Mrs. J as she puts on and takes off her blouse. It takes approximately 20 minutes per day for Mrs. J to complete this task (dressing and undressing). *Enter "7" as the number of days training and skill practice for dressing and grooming was provided.*

P3	**Nursing Rehabilitation/ Restorative Care Clarifications:**	4. Using a quad cane and a short leg brace, Mrs. D is receiving training and skill practice in walking. Together, Mrs. D and the nursing staff have set progressive walking distance goals. The nursing staff has received instruction on how to provide Mrs. D with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to apply her short leg brace following by walking. Each teaching and practice episode for brace application and walking, supervised by a nursing assistant, takes approximately 15 minutes. *Enter "7" as the number of days for splint and brace assistance and training and skill practice in walking were provided.* 5. Experiencing a slow recovery from Guillain Barre Syndrome, Mr. B is receiving daily training and skill practice in swallowing. Along with specially designed cups and appropriate food consistency, the documented plan of care to improve his ability to swallow involves proper body positioning, consistent verbal instructions, and jaw control techniques. Mr. B requires close monitoring when given food and fluids as he is at risk for choking and aspiration. Therefore, only licensed nurses provide this nursing rehabilitative intervention. It takes approximately 35 minutes each meal for Mr. B to finish his food and liquids. He receives supplements via a gastrostomy tube if he does not achieve the prescribed fluid and caloric intake by mouth. *Enter "7" as the number of days training and skill practice in swallowing was provided.* 6. Mr. W's cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration, attempts to promote his independence in feeding himself, he will not eat unless he is fed. Because Mr. W did not receive nursing rehabilitation/restoration for eating in the last 7 days, *enter "0" as the number of days training and skill practice for eating was provided.* 7. Mrs. E has amyotrophic lateral sclerosis. She no longer has the ability to speak or even to nod her head "yes" and "no". Her cognitive skills remain intact, she can spell, and she can move her eyes in all directions. The speech language pathologist taught both Mrs. E and the nursing staff to use a communication board so that Mrs. E could communicate with staff. The communication board has proven very successful and the nursing staff, volunteers and family members are reminded by a sign over Mrs. E's bed that they are to provide her with the board to enable her to communicate with them. This is also documented in Mrs. E's care plan. Because the teaching and practice in using the communication board had been completed two weeks ago and Mrs. E is able to use the board to communicate successfully, she no longer receives skill and practice training in communication. *Enter "0" as the number of days training and skill practice in communication was provided.*

P3 **(7-day look back)**	**Nursing Rehabilitation/ Restorative Care** **p. 3-191 to 3-197**	**Documentation shall be present in the clinical record for each of the above nursing rehabilitation/restorative care services during the 7-day observation period that ends with the A3a date. To be included in this section, a rehabilitation or restorative practice must meet <u>ALL</u> of the following criteria:** • **Measurable objectives and interventions must be documented in the care plan and in the clinical record.** • **Evidence of periodic evaluation by licensed nurse must be present in the clinical record.** • **Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.** • **These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.** • **This category does not include exercise groups with more than four (4) residents per supervising helper or caregiver.** **Grooming programs would need to have goals, objectives and documentation of progress included in the clinical record (per CMS).**
P7	**Physician Visits** **<u>Addendum Item</u>**	**Intent:** To record the number of days during the last 14-day period a physician has examined the resident (or since admission, if less than 14 days ago). Examination can occur in the facility or in the physician's office. In some cases, the frequency of physician's visits is indicative of clinical complexity. "<u>For validation purposes</u>, evidence (i.e., progress note, etc.) that the physician 'actually examined' the resident would need to be observed in the supporting documentation during the 14-day observation period that ends on the A3a date. A nurse's note stating, "MD here. New orders noted." would not be sufficient. Refer to CMS clarification in MDS User's Manual, p. 3-204 & 3-205.
P7	**Physician**	**Definition:** Includes an MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes an authorized physician assistant, nurse practitioner or clinical nurse specialist working in collaboration with the physician. Does NOT include visits made by Medicine Men nor licensed psychologists (PhD). The licensed psychologist (PhD) visits may be recorded in P2b.

P7	**Physician Exam**	**Definition:** May be a partial or full exam at the facility or in the physician's office. This does not include exams conducted in an emergency room. If the resident was examined by a physician during an unscheduled emergency room visit, record the number of times this happened in the last 90 days in Item P6, "Emergency Room (Visits)".
	Clarification:	♦ If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician visit. Documentation of the physician's evaluation should be included in the clinical records. The physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination. Do NOT include physician visits that occurred during the resident's acute care stay.
(14-day look back)	**p. 3-204 & 3-205**	**Documentation shall be present in the clinical record during the 14-day observation period that ends with the A3a date.**
P8	**Physician Orders**	**Intent:** To record the number of days during the last 14-day period (or since admission, if less than 14 days ago) in which a physician has changed the resident's orders. In some cases, the frequency of physician's order changes is indicative of clinical complexity.
	Physician	**Definition:** Includes an MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes authorized physician assistant or nurse practitioner or clinical nurse specialist working in collaboration with the physician.
	Physician Orders	**Definition:** Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include standard admission orders, return admission orders, renewal order, or clarifying orders without changes. Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.
	<u>Addendum Items</u>	The following examples do NOT meet DMS definition nor CMS' intent to mark as a physician's order that has changed the resident's treatment: • PT Evaluation • Change LOC from SNF to ICF • Change MD to Dr. XYZ

P8	**Physician Orders** **<u>Addendum Items</u>**	Do NOT Meet: • Move resident from Room 999 to Room 000 • D/C Skilled Level of Care • Admit to NF Level of Care • Set up eye exam with Dr. Z for treatment due to diabetic retinopathy • Send to ER P8 Exceptions: • A physician's DNR order shall be considered a valid changed order, if it is not included in the resident's admission orders, return admission orders or renewal orders without changes per DMS. • If additional physician's orders are received on the same day of admission/return admission that are NEW or CHANGE the admission/return admission orders, they shall be considered as a valid changed order. If the review nurse identifies a frequent pattern of additional orders being received on the admission/return admission days, the review nurse shall report this information to DMS. • A physician's order to discontinue (d/c) a treatment does count as a physician's order change. • A physician's order: "Clinical monitoring for problems due to antibiotic therapy for bronchitis" could be considered a physician's order change. Evidence of clinical monitoring must be observed in the resident's clinical record during the 14-day observation period to support the transmitted response for validation purposes. • A physician's order to "discontinue bedrails or bedrails up times one" during the 14-day observation period does count as a physician's order change per Task Force. • See additional CMS clarifications on p. 3-205 & 3-206 in the MDS User's Manual.
	<u>Task Force Update</u>	• A lab order is considered to be a physician's order for validation purposes if the order is documented and dated during the 14-day observation period that ends on the A3a date.
	Clarifications:	♦ A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does NOT count as an order change simply because a different dose is administered based on the sliding scale guidelines.

P8	**Physician Orders Clarifications:**	♦ Do NOT count visits or orders prior to the date of admission or reentry. Do NOT count return admission orders or renewal orders without changes. And do NOT count orders written by a pharmacist. The prohibition against counting standard admission or readmission orders applies regardless of whether the orders are given at one time or are received at different times on the date of admission or readmission. ♦ A monthly Medicare Certification is a renewal of an existing order and should NOT be included when coding this item. ♦ If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine, etc.), and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed. ♦ Orders requesting a consultation by another physician may be counted. However, the order must be reasonable (e.g., for a new or altered treatment). An order written on the last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed. ORDERS WRITTEN TO INCREASE THE RESIDENT'S RUG-III CLASSIFICATION AND FACILITY PAYMENT ARE NOT ACCEPTABLE. ♦ When a PRN order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does NOT constitute a new or changed order and may NOT be counted when coding this item. ♦ Orders for transfer of care to another physician may NOT be counted.
(14-day look back)	**p. 3-205 & 3-206**	**Documentation shall be present in the clinical record during the 14-day observation period that ends with the A3a date.**

		MDS SECTION R
R2a & R2b	**Signature of Persons Coordinating the Assessment**	Federal regulations at 42 CFR 483.20 (i) (1) and (2) require the RN Assessment Coordinator to sign, date and certify that the assessment is complete in Items R2a and R2b.
	Addendum Items	CMS Clarifications on p. 3-212: The use of signature stamps is allowed. The facility must have policies in place to ensure proper use and secure storage of the stamps. The State may have additional regulations that apply. Therefore, if the review nurse observes a blank at R2a or R2b, she/he shall continue the RUG review, document on the resident's audit worksheet that Section R2a or R2b was blank, and forward a copy of the MDS (first page and Section R) to the Department for Medicaid Services. CMS Update effective June 15, 2005: Backdating R2b on the printed copy to the date the handwritten copy was completed and/or signed is NOT acceptable.
	Coding: ***CMS Clarification Update – July 2008**	**Federal regulation requires the RN Assessment coordinator to sign and thereby certify that the assessment is complete. *Use the actual date the MDS was completed, reviewed, and signed by the RN Assessment Coordinator. This date will generally be later than the date(s) at AA9 which documents when portions of the assessment information were completed by assessment team members.**
	***CMS Clarification Update – July 2008 p. 211 & 212**	***The term "backdating" means to give or assign a date to a document that is earlier than the actual date.**

MDS SECTION AA9

AA9	**Signatures of Persons Completing These Items** **p. 3-11**	Coding: All staff responsible for completing any part of the MDS, MPAF, and/or tracking forms must enter their signatures, titles, sections they completed, and the date they completed those sections. Read the Attestation statement carefully, You are certifying that the information you entered on the MDS, MPAF, and/or tracking form is correct. Penalties may be applied for submitting false information. **Attestation Statement: "I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring the residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.**

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE* – (Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days – Not including setup

0. **INDEPENDENT –** No help or staff oversight – OR – Staff help/oversight provided only 1 or 2 times during last 7 days.

1. **SUPERVISION –** Oversight, encouragement or cueing provided 3 or more times during last 7 days – OR – Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days.

2. **LIMITED ASSISTANCE –** Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times – OR – More help provided only 1 or 2 times during last 7 days.

3. **EXTENSIVE ASSISTANCE –** While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   - Weight-bearing support
   - Full staff performance during part (but not all) of last 7 days

4. **TOTAL DEPENDENCE –** Full staff performance of activity during entire 7 days

8. **ACTIVITY DID NOT OCCUR** during entire 7 days

*The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

(B) ADL SUPPORT PROVIDED* – (Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)

0. No setup or physical help from staff

1. Setup help only

2. One person physical assist

3. Two + persons physical assist

8. ADL activity itself did not occur during entire 7 days

*The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last 7 days irrespective of frequency.

CABINET FOR HEALTH AND FAMILY SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

Minimum Criteria Required for ADL Documentation

1. **If an ADL tracking tool is used to code self-performance and support provided for coding bed mobility, transfer, toilet use and eating, the following must be clearly documented:**

   - **An observation period that ends on the assessment reference date (A3a).**
   - **If ADL documentation is not captured on a tracking tool, the observation period that ends on the assessment reference date (A3a) must be established and clearly documented.**
   - **A "key" descriptor must be available and correspond with the MDS/ADL definitions in the MDS User's Manual.**
   - **A signature must identify any staff member's initials completing the documentation (i.e., signature log is acceptable).**
   - **The month, day, year and resident's name must be clearly identified on the document source used.**

2. **The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the "entire shift" (if the information is captured every shift) or "entire 24 hours a day" (if the information is captured daily) over the last 7 days.**

3. **The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the "entire shift" (if the information is captured every shift) or "entire 24 hours a day" (if the information is captured daily) over the last 7 days, irrespective of frequency.**

   - Addendum Item: The review nurse shall NOT accept one signature/initial with a line drawn through the other 6 days of the observation period as meeting the "Minimum Criteria Required for ADL Documentation".